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ABSTRACT

This curriculum guide consists of materials for use in teaching a course in job skills for hospital ward clerks. Included in the front matter of the guide are an introduction, guidelines for using the guide, and a course outline. The second section contains a job description, seven categories of job duties and tasks, a final examination, sample certificates of completion and letters of acknowledgement for completers of training, and an achievement record. Addressed in the individual job duty sections are the following topics: receptionist activities; clerical activities; admission, transfer, and discharge activities; managerial activities; recordkeeping activities; and environmental safety and sanitation activities. Each of these sections contains some or all of the following: a duty statement, a task statement, a performance objective, a performance guide, one or more learning activities, a list of tools and equipment, an evaluation activity, and a final checklist. Appendixes to the guide contain a listing of tasks and job titles, definitions, a tool and equipment list, and a bibliography. Concluding the guide is a supplement containing various sample forms. (MN)

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V-TECS GUIDE
FOR
HOSPITAL WARD CLERK

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V-TECS GUIDE

FOR

HOSPITAL WARD CLERK

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SECTION ONE: FRONT MATTER

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This V-TECS Guide was developed via the substantial content contributions of South Carolina hospital staff who are involved in the teaching and certifying of **Hospital Ward Clerks.** The material was reviewed for use in the public high school classrooms by health occupations education instructors who teach Hospital Ward Clerk skills as part of their curricula.

Gratitude is expressed to the following committee members:

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INTRODUCTION

V-TECS guides are an extension or continuation of the V-TECS catalogs. While the V-TECS catalog is a compilation of duties, tasks performance objectives, and performance guides, it deals only with the psychomotor aspect of an occupation. It is a blueprint of an occupation. It deals only with the identification of the "hands on" aspect of the occupation. It does not take into consideration such things as the background information surrounding a task, how to make inferences, generalizations and decisions from a body of knowledge, nor does it deal with attitudes, job seeking skills, safety or energy conservation practices. V-TECS guides take these aspects of teaching and learning into consideration.

Experience has shown that the art of learning can also be taught while teaching subject matter. People need to learn how to learn. V-TECS guides take into consideration how students learn and are an efficient way for instructors to assist them to learn.

V-TECS guides are centered around all three domains of learning: psychomotor, cognitive, and effective. The following paragraphs offer a brief explanation of each domain.

PSYCHOMOTOR

Any manipulative skill such as tighten a nut, replace a hubcap, sharpen a pencil, machine a key slot in a steel shaft, or replace an SCR in a solid state control panel are examples of manipulative or psychomotor skills. Tasks such as these are identified in V-TECS catalogs. Further, V-TECS catalogs group tasks by duties and objectives. Each performance objective has a performance standard which must be met to prove student proficiency in the manipulative aspect of the task, but, the V-TECS catalog does not include any suggestions on how to learn to do these tasks.

V-TECS guides are developed around psychomotor tasks which are worker oriented.

COGNITIVE

To perform psychomotor tasks, students must think. To tighten a nut they must know which way to turn it and when to stop turning it so that they won't strip the threads or shear the bolt off. If replacing a hubcap, there is a certain technique that may vary from one car to another. For example, start the hubcap by placing the cap in a titled position and tapping it all the way around until it is properly seated. On a different model, it may be necessary to position the hubcap and snap it all at once. At any rate, students must think about what is being done. This is cognition or a mental activity. Cognition is what goes on in the mind about any job being done. V-TECS guides provide both the collateral knowledge and the impetus to apply cognition to psychomotor tasks.

Students gain cognition through both real and vicarious experiences. They may read, view tapes, memorize or practice a process or procedure until they are certain of it. To test their knowledge, students may be required to decide the proper procedure, method or sequence for performance. This is decision making or cognitive activity at its highest.

Cognition, then, is that process by which information is stored and used. That voice that warns one of potential dangers is cognition. Anything that goes on in the mind is cognition. Students may become the best workers in their job; but if they fail to think a process through, and apply their experience, they may become just one more statistic. It is cognition that tells them to lock and tag out the power supply to an electrical apparatus before starting to repair it. However, cognition does not apply only to safety. Good cognition, or thinking, can help employees do a job better and quicker. V-TECS guides provide for the cognitive aspects of learning.

AFFECTIVE

Curriculum writers, supervisors, and instructors often fail to assist students in acquiring a positive attitude toward themselves, their job, school or fellow students. V-TECS guides seek to provide assistance to the instructor in achieving this emphasis on healthy attitude. It is difficult for the instructor to identify little bits and pieces of desirable behavior for every unit and often harder yet to teach them. In this area, students might be judged on how well they clean up their work area, whether they show up to do the job in time, or whether they must be told several times to do something. Potential employers are interested in student attitude because persons angry at themselves or uncertain of themselves are often poor workers.

A student's ability to succeed on the first job and every job thereafter depends largely on attitude. If, for example, students have the attitude of "let someone else do it", they could be in trouble. Students using V-TECS guides will have activities in how to get along with others, with supervisors or staff members and in large and small groups.

USE OF V-TECS GUIDE

The guide is designed to provide job-relevant tasks, performance objectives, performance guides, resources, learning activities, evaluation standards and achievement testing in selected occupations.

A V-TECS guide is designed to be used with any teaching methods you may choose. If a lecture/demonstration method is best for you, you will find sufficient help to meet your needs. If you prefer to use discussions or other methods that require student participation, you will find ample help. Regardless of which method is successful for you, a V-TECS guide can save preparation time and offer innovative methods and procedures. For example, students may work either alone or in teams while in class and learn skills in direct relation to what is actually done on the job. Furthermore, this work takes into consideration student attitudes, their thinking skills, as well as mathematical reading skills.

The use of small groups in teaching can be helpful in a number of ways: (1) many students may feel inadequate due to their lack of background information in mechanical things; (2) some may feel that they are physically incompetent or lack the necessary background experiences. A successful program (course) can provide students with a sense of security by reinforcing positive attitudes while improving their skills and knowledge of the subject. By allowing students to interact on a personal level, this task/learner-centered approach can achieve this healthy attitude. As students gain confidence and discover that they are an essential part of a team engaged in the learning-teaching process, their confidence increases. Too, the student in this setting can learn to work without direct supervision. In addition, use of the small-group method permits the instructor to vary instructional routines away from lecture or other full-class methods to activities for single students, pairs of students or any number so desired.

You will find suggestions for specific classroom activities. These activities are not meant to restrict you or your students, but only to suggest a variety of learning activities for each task statement. Please do not feel that you must take your students through all the activities.

SOUTH CAROLINA MODIFICATIONS

In twelve instances, the South Carolina writing team elected either to combine tasks and/or to delete them. Deletions were made only when 100 percent of the team agreed that the task had become archaic.

The following tasks were omitted:

- Locate patient/chart whereabouts. (performance objective #10)
- Order and cancel TV sets, radios. (performance objective #11)
- Order guest trays. (performance objective #12)
- Prepare Kardex cards. (performance objective #49)
- Prepare medicine or treatment cards. (performance objective #56)
- File and retrieve assorted forms. (performance objective #60)
- Maintain patient information card file or roster. (performance objective #64)
- Assist in transportation of patient by stretcher. (performance objectie #87)
- Transport patient by wheelchair. (performance objective #88)

The remaining three tasks were incorporated into other material:

- Make appointments for patients. (performance objective #9)
  Included in (performance objective #48) "Clerically discharge patients."
- Make arrangements for blind, deaf, helpless, aged, or irrational patient on admission. (performance objective #34)
  Included in (performance objective #47) "Clerically admit patients."
- Prepare blood requisitions. (performance objective #71)
  Included in (performance objective #61) "Prepare laboratory requisition forms(s)."

Finally, the South Carolina writing team chose to include a sample job description and a suggested final examination which may be used as a guideline for preparation. In addition, a sample certificate and a letter of acknowledgment to completers of training are contained. For those instructors who wish to maintain documentation, an achievement record is provided.

COURSE OUTLINE
FOR
HOSPITAL WARD CLERK

The writing committee suggests that the instructor adhere to the following sequence when teaching the various tasks performed by the hospital ward clerk. Estimated lengths of teaching time are cited for planning purposes.

	UNITS of INSTRUCTION (DUTIES AND TASKS)	**Suggested Teaching Time**	**Page**
-	JOB DESCRIPTION -	1 hour	11
I.	**PERFORMING RECEPTIONIST ACTIVITIES**	8 hours	16
A.	Greet and direct professionals, (new patients), and visitors to patient location.		
B.	Accept incoming telephone calls and relay messages.		
C.	Call physician's answering service or office and relay messages.		
D.	Answer pages, page persons.		
E.	Accept and direct mail, flowers, gifts.		
F.	Arrange special visiting privileges.		
G.	Greet physician and provide patients' charts.		
II.	**PERFORMING CLERICAL ACTIVITIES (INTERNAL COMMUNICATION SYSTEMS)**	4 hours	47
A.	Initiate and respond to telecom/intercom communications.		
B.	Receive and send articles by dumb waiter or pneumatic tube.		
III.	**PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES**	20 hours	85
A.	Assemble/disassemble addressograph plate.		
B.	Initiate graphic sheet.		
C.	Graph temperature, pulse, respiration.		
D.	Chart data from information supplied such as weight, B.P., diet, B.M., I. & O.		
E.	Check new patient's allergy record, (Patient History), flag chart and Kardex (appropriate forms).		
F.	Prepare medicine sheets (Medication Administration Record {MAR}).		

G. Prepare requisitions for routine diagnostic tests.
H. Institute/change/discontinue diet service.
I. Clerically admit patients.
J. Transcribe admission orders.
K. Route delayed diagnostic reports of discharged/transferred patients.
L. Deposit or withdraw patient's money or valuables from safe.
M. Clerically transfer patients.
N. Clerically discharge patients.
O. Instruct patient or family of discharge procedures.
P. Assemble and check chart for medical records on discharge.
Q. Prepare credit slip for return of unused medication.
R. Perform clerical discharge procedure for deceased patient.
S. Prepare a replacement patient identification band.

IV. PERFORMING CLERICAL ACTIVITIES 16 hours 245

A. Obtain signatures on consent, against advice, or release forms.
B. Prepare and maintain TPR and diet worksheet.
C. Prepare pharmacy requisitions.
D. Prepare and route X-ray requisitions.
E. Prepare and route special therapy requisitions.
F. Obtain X-rays.
G. Arrange escort and transportation services for therapy elsewhere.
H. Arrange for ordered consultations.
I. Discontinue all orders when patient goes to surgery.
J. Distribute forms and articles from "in" basket.
K. Execute pre-op chart check.
L. Prepare laboratory requisition form(s).
M. Place/remove special bedside directives.
N. Prepare and route medication index forms.
O. Inspect and report expiring narcotic or antibiotic orders.
P. Photocopy chart forms.
Q. Prepare addressographed nurses' notes sheets for each patient.

V. PERFORMING MANAGERIAL ACTIVITIES 8 hours 360

A. Locate assistants for therapists and technicians.
B. Brief oncoming ward clerk.
C. Dispense and charge supplies.
D. Check and route patient food trays.
E. Initiate codes upon nurses' directives.
F. Initiate and route incident or accident reports.
G. Prepare and route report forms.
H. Arrange maintenance and repair of equipment.
I. Prepare and maintain a laboratory and X-ray "Hold Diet" sheet.
J. Prepare a supply of assembled packets for admission, surgery, discharges.
K. Maintain inventories of supplies and equipment.
L. Trace lost and found articles.
M. Obtain and charge special equipment.
N. Provide orientation to newly employed workers.
O. Prepare and route supply requisitions.
P. Assist in supervision of ward clerk students.
Q. Refer patient complaints or problems to a corrective department.
R. Receive and store supplies and equipment.
S. Schedule patient treatments or therapy with other hospital departments.
T. Select and mark needed special hour TPR's on worksheet (graphic sheet).
U. Trace missing lab specimen or reports.

VI. PERFORMING RECORD KEEPING ACTIVITIES 4 hours 444

A. Prepare and maintain daily census sheet.
B. Add chart forms as needed.
C. Obtain and safeguard prior admission chart.
D. Post all diagnostic reports on charts.
E. Prepare and add supplemental forms to charts such as diabetic record, coagulation record, physical therapy record, etc.
F. Prepare, maintain, and post/route lists.

VII. **MAINTAINING ENVIRONMENTAL SAFETY AND SANITATION** 4 hours 468

A. Prepare for ordered isolation care.
B. Plan/execute nursing station sanitizing.
C. Enforce regulations governing care of charts.
D. Replace outdated supplies.

- **FINAL EXAMINATION** - 2 1/2 hours 483

SECTION TWO: Components

JOB DESCRIPTION (A SAMPLE)

JOB TITLE	JOB CODE	EEO CENSUS CODE	JOB GRADE
Hospital Ward Clerk	G-050	5	5
ADMINISTRATIVE SERVICE	DEPARTMENT/AREA		
Hospital Operations-A	Unit Management		
VERIFIED BY PERSONNEL DIRECTOR	DATE	POSITION SUPERVISOR	
		Ward Manager	

JOB SUMMARY

Working as a part of the clinical nursing unit, the Hospital Ward Clerk performs clerical tasks, assists nurses in the daily work of preparing, compiling and maintaining patient charts. Reads and transcribes physicians' orders. Checks, verifies and arranges the patients' charts for admitting, transferring and discharging. Schedules all patient tests and procedures as ordered by the physician and directed by the nursing staff. Inventories supplies on the exchange cart and notifies charge nurse of missing items. Completes timekeeping duties. Answers intercom and phone and relays messages to the appropriate personnel. Acts as a receptionist, greeting newly admitted patients, giving directions to visitors and helping other personnel unfamiliar to the ward. Carries out all nonclinical clerical responsibilities. Must be willing to work on different wards as need arises.

QUALIFICATIONS

This employee must be a high school graduate, or have a G.E.D. certificate. Individuals must be eighteen (18) years of age. Clerical experience is preferred but not essential. Selected individuals will receive two (2) weeks of classroom training and a minimum of two (2) weeks on-the-job training. All newly hired ward clerks must successfully complete the two (2) week training course. A score of 85 must be achieved on the final examination along with a successful evaluation from the Ward Clerk Education Coordinator.

Individuals selected for this position must:

1. Be able to assume responsibility.
2. Be able to handle mental and physical stress.
3. Be prompt and accurate.
4. Be polite and courteous.
5. Be articulate and have a neat appearance.
6. Be an emotionally mature individual.

7. Become familiar with medical terminology.
8. Be well organized.
9. Have legible handwriting.
10. Be cooperative when asked to work on another unit.

RESPONSIBILITIES

1. Answers telephone courteously, stating the ward, name and title, and giving messages to appropriate personnel.
2. Answers calls on the intercom and relays request to the appropriate personnel.
3. Handles all information received or given on the unit with conciseness and accuracy.
4. Uses proper channels and methods for relaying information.
5. Relays **any** information that is necessary to co-workers.
6. Answers questions clearly and concisely.
7. Communicates effectively with the physicians, nursing personnel, other department personnel, the patients, and family.
8. Acts as a receptionist to newly admitted patient by receiving fact sheet, name plate, and hemotology requisition.
9. Informs nursing personnel of newly arrived patient.
10. Stamps each form on the new patient chart, using the patient's nameplate on the addressograph, arranging them in the proper sequence, and filling in required information.
11. Identifies patient chart with patient's name and room number, physician's name and color code for chart rack.
12. Stamps appropriate care plan according to the admitting diagnosis for the nursing care plan notebook.
13. Stamps MAR for medication care notebook, and completes information.
14. Reads and transcribes the physician's orders to the care plan and the MAR.
15. Transcribes all medication, hours, dosage and date to the MAR.

Hospital Ward Clerk Job Description

16. Transcribes X-ray, lab tests, physical therapy, IV administration, special procedures and blood administration orders to the Care Plan Notebook in an expedient manner.

17. Phones stat orders to the appropriate department.

18. Insures that the following are recorded on the graphic sheet:

    a. TPR's, BP, height, weight
    b. Dateline
    c. Hospital and surgical days
    d. Urine and stools
    e. Diet and diet intake, 3 meals daily

19. Notes any special information such as NPO, allergies, isolation, etc., by placing labeling tape on the front of the chart.

20. Completes requisitions and schedules all patient tests as ordered by physician.

21. Insures that test results and reports are filed on patient chart as quickly as possible and when transferred, write transfer unit at top of requisition.

22. Checks the MAR daily for expired drugs and carries out procedure.

23. Orders diets and reports changes to dietary as directed by physician's order.

24. Checks each chart daily and makes sure they are currently up to day.

25. Completes dietary requisition forms daily.

26. Identifies, distributes, makes certain that menus are completed and collected by 10:30 a.m. Marks special diets as directed.

27. Compiles and maintains an adequate number of made up charts.

28. Must complete pharmacy requisition slips for patient medication per physician's order.

29. Must order and notify the pharmacy when an IV medication is discontinued along with completing a DC, IV slip.

30. Completes the following for a patient discharged:

    a. Directing patient or representative of the patient to take discharge slip to business office.
    b. Breaking down chart.
    c. Stamping all unidentified forms in chart.
    d. Crediting all drugs to the pharmacy.
    e. Canceling diet.
    f. Insuring all signatures are obtained before releasing the chart.

  g. Notifying flower and mail desk, dietary, housekeeping, patient information and the admitting office, lab, and the physician's office of the discharge.

31. Completes the following for a patient transfer:

  a. Updating the chart as needed, checking for all signatures and identifying all forms.
  b. Obtaining all medications for patient from drug cart.
  c. Notifying flower and mail desk, dietary, housekeeping, patient information and the admitting office, lab and the physician's office of the transfer.

32. Makes return office appointment and orders take-home drugs when patients are discharged as ordered by the physician.

33. Completes burial transit form, consent form #17 and patient activity slip when patient expires.

34. Completes housekeeping daily census report of all admissions, transfers, discharges, and deaths. Must be delivered to admitting office prior to 10:30 p.m. with patient activity slips.

35. Completes housekeeping slip and notifies housekeeping by phone when patient clears the business office or is transferred to another ward.

36. Completes time keeping duties as follows:

  a. Complete "record of time taken" on the back of the time card at the end of the first week of the pay period.
  b. Complete "record of time taken" on the back of the time card, and checks for signatures at the end of the second week of the payroll.
  c. Takes all time cards to payroll on Sunday, (when the operator announces timekeeping is open) prior to the Thursday payday.
  d. Picks up new time card from nursing administration prior to 12 noon on the Friday prior to the Thursday payday.
  e. On payday takes names and employee numbers to nursing administration by 9:00 a.m. Picks checks back up after 10:00 a.m.

38. Orders floor stock drugs every Monday, Wednesday, and Friday.

39. Replenishes forms and care plans as needed from print room in the basement. This will be done between the a.m. - p.m. overlap period or at any other time deemed necessary.

40. Notifies Ward Manager or Evening Administrator (5-11 p.m.) of any problems with supporting departments or services and notes this for the Ward Manager in the Ward Manager's Log Book.

41. Notifies p.m. Administrator if history and physical is not on chart when a patient is scheduled for surgery by 9:00 p.m.

42. Notifies Ward Manager or Evening Administrator (5-11 p.m.) of any problems with supporting departments or services and notes this for the Ward Manager in the Ward Manager's Log Book.

43. Notifies Ward Manager of any discrepancy seen in housekeeping work.

44. Attends any meeting or class as instructed by the Ward Manager.

45. Must be visible in the hallway during a Mayday to direct the Mayday Team to the proper room.

46. Must be at nursing station during the Mayday to assist the ward for all non-clinical needs during the emergency.

47. Completes the schedule from patient care notebook for the next day's patient treatment.

48. Examines controlled drug book or medicine drawer for drug charge requisitions and stamps these slips with the appropriate patient card.

49. Makes NPO stickers so that nursing assistants can put them on patient doors.

50. Examines charts to insure that only black and red are being used on the chart.

51. Even though hired for a specific ward, there will be times when the need on other units will require that a Ward Clerk be pulled to work on another ward.

52. Assists in on-the-job training for all new Hospital Ward Clerks.

DUTY: PERFORMING RECEPTIONIST ACTIVITIES

TASK: Greet and direct professionals ...(new patients)... and visitors to patient location

---

PERFORMANCE OBJECTIVE

Given the necessary information and three persons seeking directions: direct the persons to their desired location. Standard policies must be observed, and the directions given must result in the persons arriving at their desired location without undue delay. (4)

PERFORMANCE GUIDE

1. Greet the person(s) approaching the nursing station promptly and offer assistance courteously.
2. Establish each person's purpose in the area.
3. Check the Kardex ...(patient chart)... for any special orders or restrictions concerning this patient.
4. Recognize undesirable or inappropriate visitor behavior and seek assistance if needed.
5. Direct persons to their desired locations clearly, explicitly, and understandably, if in the best interest of the patient as determined by the nurse.
6. Answer any questions within ward clerk limitations.

LEARNING ACTIVITIES

1. Demonstrate:
   a. Smiling at person(s) and asking, "May I help you?"
   b. Tactfully seeking person's purpose in being in the area.
2. Role play the giving of precise and clear directions.
3. Review patient care form (attached) or talk with nurse concerning patient orders or restrictions, if any.
4. Demonstrate a call to security for assistance with a visitor who exhibits undesirable or inappropriate behavior. Post the security phone number in easily accessible place.
5. Review information on Job Description and responsibilities.
6. Perform three greetings and directions in mock situation for evaluation by the instructor.

TOOLS AND EQUIPMENT

patient care form

EVALUATION

Using provided information, the student will greet and direct three professionals, new patients, or visitors to their desired locations. Standard policies demonstrated during instruction must be observed; the directions given must result in the persons arriving at the desired location without undue difficulty or delay. Performance must ultimately result in a "fully accomplished" rating by the instructor.

RE-OPERATIVE PATIENT

V - TECS 6
L.A. #3

Admission Date ____ BATH: Self Assist Bed

Classification ____

Diet ____

Diet ____

Diagnosis ____

Surgery ____

Attending Physician(s):

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			Vital signs (T, P, R, and BP) on admission and	Afebrile (less t
			@ HS prior to surgery and AM of surgery. Pre-	99.6) 12 hours
			pare for surgery as ordered:	prior to surgery
				Establishment of
				baseline vital
				signs.
			Up ad lib unless contraindicated.	Ambulatory
			1. Give verbal and/or written explanation of	Verbalizes
			preparation for surgery and of post-op care.	instructions
				regarding proce-
				dures and coopera
			2. Explain operative permit to patient and	with plan of care
			witness patient's signature.	Informed consent.

BEST COPY AVAILABLE

V-TECS 6
L.A. #6

STUDENT____________________________

DATE_______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:
Greet and direct professionals, (new patients), and visitors to patient location.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When greeting and directing professionals ...(new patients)... and visitors to patient location, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Greeted the person courteously, offered assistance and verified persons purpose in the area.	( )	( )	( )	( )	( )
2. Identified undesirable or inappropriate visitors behavior and sought assistance as needed.	( )	( )	( )	( )	( )
3. Directed persons to their desired location.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECEPTIONIST ACTIVITIES

TASK: Accept incoming telephone calls and relay messages

PERFORMANCE OBJECTIVE

Given three incoming calls and access to information and equipment: accept the calls and relay the messages. All items on the instructor's checklist must be rated "fully accomplished." (4)

PERFORMANCE GUIDE

1. Give the proper salutation, identifying the area, yourself, and your position. The recognition of barriers to successful communication is an essential element of all conversation.
2. Listen attentively, determine the nature of the call.
3. Exhibit behavior that indicates concern for people — courtesy and self-control, exercising tact when denying information.
4. Use appropriate terminology, clarity of expression, diction, and grammar.
5. Record the name of the caller, time, and message legibly: who, what, when, where, why, and how.
calling.
6. Verify the information you recorded by repeating it to the person calling.
7. Exhibit awareness of time constraints.
8. Take appropriate action regarding the call, recognizing ward clerk limitations. Note: Types of calls on most nursing units include, but are not limited to, the following:
    a) requests for information concerning patient's condition or well-being
    b) requests from admission office concerning room occupancy restrictions and patient placements
    c) information concerning planned admissions
    d) information concerning emergency admissions with special equipment needs
    e) messages for physicians or staff on the unit, including emergency calls
    f) contingency calls regarding O.R. schedules, pre-op orders, special services
    g) information concerning transfers in, out, or within unit
    h) physicians seeking to convey orders by telephone
    i) coordination of patient activities with other hospital departments
    j) codes, emergencies, etc.
    k) blood is ready to be picked up
9. If it is necessary to "hold" the call, do not disconnect the caller and do re-enter to reassure caller.

10. Seek assistance if needed.
11. Make certain the call is satisfactorily completed before disconnecting.
12. Relay the message promptly.

LEARNING ACTIVITIES

1. Discuss telephone etiquette and telephone manners. Distribute and discuss information sheet titled "Keep Your Image in Mind."
2. View the film "Telephone Dimension System." Review in small groups transferring calls, putting calls on hold and other features of telephone system.
3. Listen to resource speaker from local telephone company on topic - Telephone Etiquette.
4. Role play situations involving incoming telephone calls and relaying messages.
5. Orally perform items on instructor's checklist.

RESOURCES

film: "The Telephone Dimension System"
Southern Bell
1981

resource speaker from local telephone company

TOOLS AND EQUIPMENT

telephone
message pad
writing materials
film
film projector

EVALUATION

Given three incoming calls and access to information and equipment, the student will accept the calls and relay the messages. All items on the instructor's checklist must be addressed and rated "fully accomplished."

KEEP YOUR IMAGE IN MIND
TELEPHONE MANNERISMS

HOW DO YOUR HOSPITAL'S CALLERS REACT TO THE WAY YOU RESPOND TO THEIR TELEPHONE BUSINESS AND INQUIRIES? DOES YOUR TELEPHONE TREATMENT ENHANCE YOUR PERSONAL AND DEPARTMENTAL IMAGE, OR MAR IT?

YOUR RESPONSE WILL BE "ENHANCE" IF YOU ADHERE TO THE FOLLOWING SIMPLE RULES OF GOOD, IMAGE-BOOSTING TELEPHONE USE:

1. First of all be a good listener. Listen with your full attention. Concentrate. Make a conscious effort to absorb and understand what the caller is saying. Get your mind actively on the job: don't permit it to wander.

2. Make the caller feel important. Get the message across by means of the interest and care in your voice, that the caller's business is important to you, that what the caller has to say is significant, and that you will go all out to satisfy the caller's request. When you answer his or her call, give the caller a big friendly hello. Make the caller feel like the VIP that he or she really is.

3. Don't "hem" or "haw." If you don't understand fully, or have the information the caller seeks, quickly switch the caller to someone who does. If the call is strictly your responsibility, don't fake understanding if you're hazy. Ask the caller to explain what he or she means. The caller will respect you more if you do. If you don't have the information he or she requires on hand, tell the caller you'll check it out and call him or her back. And do so within a reasonable period of time.

4. If the caller has a complaint, remember that it's important to give the caller an opportunity to express it. What the caller probably wants most of all is a sympathetic ear. The objective is to placate and calm the caller, not proving that you're right and the caller is wrong.

5. Be polite, businesslike, and dignified, but deformalize the conversation within bounds. We're living in an automated, computerized era, and many people are very irritated by depersonalized dealings. Respond to the person on the other end of the line as if you realize that both of you, in addition to fulfulling the job functions for which you are paid, are human beings with sensitivity as well. Come across as a person, not an impersonal voice.

V-TECS 2
L.A. #5

STUDENT____________________________

DATE_______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Accept incoming telephone calls and relay messages.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When accepting incoming telephone calls and relaying messages, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Answered phone by his/her own name, identifying unit and title.	( )	( )	( )	( )	( )
2. Recorded name of caller and determined nature of call.	( )	( )	( )	( )	( )
3. Referred the caller to the appropriate department or person if the requested information was not available or beyond the ward clerk's limitations.	( )	( )	( )	( )	( )
4. Verified the telephone number and returned the call with the requested information if necessary.	( )	( )	( )	( )	( )
5. Relayed accurate, complete message in legible handwriting to appropriate person promptly.	( )	( )	( )	( )	( )
6. Used accurate terminology, and clarity of expression, grammar, diction, and tone of voice.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECEPTIONIST ACTIVITIES

TASK: Call physician's answering service or office and relay messages

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PERFORMANCE OBJECTIVE

Given the telephone, appropriate numbers, and three requests to call the answering service or doctor's office: place the calls, accept and relay the messages. All items on the instructor's checklist must be rated "fully accomplished." (4)

PERFORMANCE GUIDE

1. Place the call to the physician's answering service or office courteously, identifying self and location.
2. Record name and position of the person answering with the date and time of call.
3. State why you are calling, using tact and discretion.
4. Write the messages.
5. Ask for additional data if message seems incomplete.
6. Verify accuracy of your recording by repeating it back.
7. Use appropriate telephone manners, grammar, diction, and terminology.
8. Relay the written messages promptly.

LEARNING ACTIVITIES

1. Discuss telephone etiquette and telephone manners. Refer to information sheet titled "Keep Your Image in Mind" (Lesson 2, V-TECS 2).
2. Role play with classmates the calling of physician's answering services.
3. Practice the steps of calling physician's answering service or office and relay messages by following the items listed on the instructor's checklist.
4. Visit a site which has an answering service in active operation.
5. Perform the items listed on the instructor's checklist until receiving a "fully accomplished" rating.

RESOURCES

answering service site

TOOLS AND EQUIPMENT

telephone
telephone directory
message pads
writing materials

EVALUATION

Using provided materials and information, the student will call three physicians' answering services or offices and rely the messages as requested. All items on the instructor's checklist must be addressed and rated as "fully accomplished."

V-TECS 5
L.A. #5

STUDENT ____________________

DATE ____________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Call physician's answering service or office and relay messages.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When calling physician's answering service or office and relaying messages, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Dialed correct telephone number.	( )	( )	( )	( )	( )
2. Recorded name of person answering, date and time of call, and messages.	( )	( )	( )	( )	( )
3. Identified self, position and location, and stated tactfully the purpose of the call.	( )	( )	( )	( )	( )
4. Verified accuracy of messages and gave physician written messages.	( )	( )	( )	( )	( )
5. Displayed cooperative, courteous attitude.	( )	( )	( )	( )	( )
6. Used appropriate terminology, diction, and grammar.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECEPTIONIST ACTIVITIES

TASK: Answer pages; page persons

PERFORMANCE OBJECTIVE

Given the appropriate public address system equipment, writing materials, and described opportunities: accept three pages and relay the messages; place pages for three persons. All items on the instructor's checklist must be rated "fully accomplished." (4)

PERFORMANCE GUIDE

When answering pages:

1. Listen to the paging system for anyone present on this unit and inform person of the page.
2. Call the operator for the message if so requested, identifying yourself and stating the reason you are answering the page.
3. Place the call, recording the area, name, and position of answering person.
4. Record and relay the message accurately and quickly.
5. Use acceptable telephone manners, grammar, diction, and terminology.
6. Exercise tact and discretion.

When paging persons:

1. Call the switchboard operator identifying the unit, yourself, and your position, and request the operator to page the person you want, giving accurate information or ...
2. Dial a specified number and page the person yourself supplying accurate, adequate information using a pleasant tone of voice and articulating clearly.
3. Remain at the telephone to receive the response message.
4. Relay the response to the appropriate person(s) promptly.

LEARNING ACTIVITIES

1. Explain and demonstrate the paging system according to prescribed policy of the individual setting.
2. Review information sheet titled "Keep Your Image in Mind" (Lesson 2, V-TECS 2).
3. Simulate three opportunities requiring use of the public address system.
4. Observe classmates as they role play responses to the simulations. Evaluate aloud their strengths and weaknesses.
5. Perform the items listed on the instructor's checklist until receiving a "fully accomplished" rating.

TOOLS AND EQUIPMENT

- telephone
- public address system
- writing materials

EVALUATION

Using the provided equipment and information, the student will accept three pages; page three persons. All items on the instructor's checklist will be addressed and rated "fully accomplished."

V-TECS 3
L.A. #5

STUDENT ______________________________

DATE ______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Answer pages.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When answering pages, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Told persons on unit they are being paged.	( )	( )	( )	( )	( )
2. Called operator; identified self, position and unit; and stated reason for answering page.	( )	( )	( )	( )	( )
3. Recorded name of caller along with appropriate information to identify patient or type of request.	( )	( )	( )	( )	( )
4. Verified the phone number and returned the call with the requested information, if needed.	( )	( )	( )	( )	( )
5. Relayed messages promptly in writing to appropriate person: who, what, when, where, why, how.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

V-TECS 3
L.A. #5

STUDENT____________________________

DATE_______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Page persons.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When paging persons, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Placed page correctly.	( )	( )	( )	( )	( )
2. Used correct terminology, diction, and tone of voice.	( )	( )	( )	( )	( )
3. Remained at phone to respond and gave accurate information.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECEPTIONIST ACTIVITIES

TASK: Accept and direct mail, flowers, gifts

PERFORMANCE OBJECTIVE

Given the standard policies, the patient's Kardex cards, ...(or patient care form and physicians' orders)... and an assortment of mail and gifts: accept and direct the mail, gifts, and flowers, or state the reason for rejecting. All restrictions must be observed. Performance must conform to established policies and be acceptable to the instructor. (4)

PERFORMANCE GUIDE

1. Identify whether or not the article is for a patient on this unit.
2. Sign for article following hospital policies.
3. Check Kardex ...(patient card form or physician's order)... for special orders or restrictions regarding patient.
4. Seek direction from charge nurse if needed.
5. Deliver or assign an appropriate person to deliver the article -- handling it with due care and considering its perishability.
6. Place article in an appropriate location in patient's room.

LEARNING ACTIVITIES

1. Discuss a sample policy of a patient care facility in order to learn how to determine which patients may receive mail, flowers, and gifts. Investigate the reasons that certain types of patients (e.g., isolation, intensive care, etc.) may not receive these items.
2. Take a field trip to a patient care facility to observe a standard policy being executed.
3. Practice identifying special orders or restrictions using the attached sample patient care form and daily census report.
4. List on paper the steps involved in accepting and directing mail, flowers, and gifts.
5. List on paper the correct procedure for rejecting mail, gifts, and flowers.
6. Role play in front of the entire class the process of accepting and rejecting mail, gifts, and flowers.
7. Demonstrate to the instructor the proper procedure for receiving and rejecting mail, gifts, and flowers; achieve a rating of "fully accomplished."

TOOLS AND EQUIPMENT

physician's orders
mail
flower
gifts
Kardex or patient care form
standard policies of patient care facility

EVALUATION

Using provided material, the student will properly accept and accurately direct patient mail, gifts, and flowers. All restrictions will be observed. Actual performance according to established policies must be rated as "fully accomplished" by the instructor.

PRE-OPERATIVE PATIENT FOR ADULT SURGERY

V - TECS 1
L.A. #3

Admission Date ______ BATH: Self Assist Bed
Classification ______
Diet ______
Diet ______
Diagnosis ______
Surgery ______

Attending Physician(s):

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			Vital signs (T, P, R, and BP) on admission and @ HS prior to surgery and AM of surgery. Prepare for surgery as ordered:	Afebrile (less t 99.6) 12 hours prior to surgery Establishment of baseline vital signs.
			Up ad lib unless contraindicated.	Ambulatory
			1. Give verbal and/or written explanation of preparation for surgery and of post-op care.	Verbalizes instructions regarding procedures and cooper with plan of care
			2. Explain operative permit to patient and witness patient's signature.	Informed consent.

BEST COPY AVAILABLE

FOR: Appendectomy Post ICU Gastrectomy Abdominal Surgery, Adult
Hernia Exploratory Laparptory
Pilonidal Cyst Cholecystectomy

V - TECS 1
L. A. #3

Admission Date ____________ BATH: Self Assist Bed
Classification ____________
Diet ____________
Diet ____________
Diagnosis ____________
Surgery ____________ Page 1

Attending Physician(s):

____________ ____________
____________ ____________
(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			1.A. Vital signs (T, P, R, and BP) every 4 hrs.	Afebrile (te
			x 72 hours.	less than 99.6
			B. DC at _____am/pm on _____________.	24 hrs. prior
			Then routine q __________ hrs.	discharge.
			C. Turn, cough, deep breathe every 2 hrs.	
			x 24 hours.	
			Assist patient to splint incision as	
			necessary.	
			2.A. Check dressing(s) every 4 hrs. x 24, then	Clean healing
			QID	wound.
			B. If prn dressing change order:	
			Change dressing at least daily to observe	
			wound area for redness, swelling, increased	
			drainage, healing.	
			C. Note presence of:	
			Drain__________ Removed__________	
			Skin clips__________ Remove __________	
			Staples__________ Remove __________	
			Sutures__________ Remove__________	
			Steri-strips__________	
			T-tube______ Empty_____ Removed__________	
			Hemovac______ Empty_____ Removed__________	
			Other__________	

FOR: Appendectomy Cholecystectomy Abdominal Surgery, Adult
Hernia Post ICU Gastrectomy
Pilonidal Cyst Exploratory Laparotomy

V - TECS 1
L. A. #3

Admission Date ____________ BATH: Self Assist Bed

Classification ____________

Diet ____________

Diet ____________

Diagnosis ____________

Surgery ____________ Page 2

Attending Physician(s):

____________ ____________

____________ ____________

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			3.A. I & O every 8 hrs. ____________	Normal bladder
			B. DC at ________ am/pm on ____________	function restore
			if voiding freely and taking po fluids.	
		(Cath order)		
			4. Levine tube____________ Salem sump________	Bowel function
			Connect to____________	restored (1 BM
				prior to discharg
			Irrigate with____________	Tolerating diet.
			Remove NG tube (date)____________	
			5.A. Elevate foot of bed 3" x 8 hrs. (if ordered)	
			B. Lower foot of bed at ________ am/pm	
			on ____________.	
		(Ambulation orders)		Ambulatory

FOR: Appendectomy Abdominal Surgery, Adult
Hernia Post ICU Gastrectomy
Pilonidal Cyst Exploratory Laparotomy

V - TECS 1
L. A. #3

Admission Date ____________ BATH: Self Assist Bed

Classification ____________

Diet ____________

Diet ____________

Diagnosis ____________

Surgery ____________ Page 3

Attending Physician(s):

____________ ____________

____________ ____________

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			Discharge____________	
			6. Instruct patient and/or significant other	
		(Date and Initials)	in the following:	Patient verbali
		____________	A. Follow-up appointment____________	understanding a
		____________	B. Activity limitations	or demonstrates
		____________	C. Wound Care	discharge instru
		____________	D. Take home drugs	tions.
			E. Special diet	
			Reinforce physician's instructions	

V - TECS 1
L.K. #3

BEST COPY AVAILABLE

DAILY CENSUS REPORT

FLOOR 3rd - Long CENSUS 12:00 MIDNIGHT 12- 15 DAT

ADMISSIONS				DISCHARGES		
NO.	TIME	NAME		NO.	TIME	NAME
392-1	2 45 Pm	Miss Ann Maginnis	301	1	9:50 Am	Mr. Willie Caldwell
301-1	3:10 Pm	Mrs Ruth Boozer				
305-2	3:00 Pm	Mrs Mary Rhinehart				
305-1	3:40 Pm	Mrs Elizabeth Bradham				
392-2	4:25 Pm	Mrs Cecil Dial				
309-1	4 10 Pm	Mrs Betty Koon				

RECEIVED BY TRANSFER				DISCHARGED BY TRANSFER		
NO.	FROM DIV.	NAME		NO.	TO DIV.	NAME
394-1	ICU #3	Fred Flagg				
374-2	206	Horace Holmes				
302	ICU #2	Sam Surrey				

309-1 to 309-2 Koon

DEATHS		
NO.	TIME	NAME

	MALE Adult	MALE Newborn	FEMALE Adult	FEMALE Newborn
Remaining Last Report	4		5	
Admitted	0		5	
Received Per Transfer	3		0	
Total	7		10	
Discharged	1		0	
Died	0		0	
Remaining 12:00 Midnight	6		10	

Total - 16

Form A1-2 4/74

V-TECS 1
L.A. #7

STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Accept and direct mail, flowers, gifts.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When accepting and directing mail, flowers, gifts, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Verified location of patient and signed for article following hospital policies.	( )	( )	( )	( )	( )
2. Delivered article to patient's room.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECEPTIONIST ACTIVITIES

TASK: Arrange special visiting privileges

PERFORMANCE OBJECTIVE

Given the authorization for special visiting privileges for three patients, the kardex file ...(or patient care form)..., special signs, and the required information: arrange for special visiting privileges. Arrangements made must conform to posted policies of the institution. (4)

PERFORMANCE GUIDE

1. Identify special visiting privileges to be arranged, consulting the charge nurse for authorization and directives.
2. Place a note for authorization and directives.
3. Place the designated sign on the door of the patient's room.
4. Notify the appropriate hospital department(s) of special privilege(s): business office, information desk, switchboard, housekeeping department, etc.
5. Make local or long distance calls as needed and charge correctly.
6. Reassure the person called.
7. Inform visitors of hospital policies in regard to special visitors.
8. Provide for the basic physical needs of the long-term visitor (cot, food service, etc.).
9. Seek assistance as needed if visitor becomes emotionally disturbed.
10. Follow established policy if a visitor falls, is injured in any way, or becomes ill.

* Suggestion of South Carolina writing team: Omit numbers 5 and 6.

LEARNING ACTIVITIES

1. Discuss with a representative the procedure for identifying special visiting privileges. (Review the content and purpose of the physician's order form).
2. Discuss and demonstrate procedure for placing order on patient care form. (Refer to attached sample.)
3. Visit a unit and observe where the signs are kept and learn the procedure for posting.
4. Explain procedure for notifying appropriate departments (i.e., telephone, giving name, unit, title, patient's name and room number and special instructions).
5. Role play giving information to visitors.
6. Explain procedure for providing basic physical needs of the visitor according to patient care facility policy. (i.e., Call appropriate department and give special instructions.)
7. Explain procedure for taking care of visitor falls, injuries, or illnessess, according to patient care facility policy.

8. Show mastery of task (i.e., arranging special visiting privileges) by performing it in a manner acceptable to the instructor.

TOOLS AND EQUIPMENT

special signs
Kardex or patient care form

EVALUATION

Using provided information and materials, arrange in writing special visiting privileges for three patients. Arrangements must conform to the institutional policy provided by the instructor. The instructor must rate the written arrangement as "fully accomplished."

PRE-OPERATIVE PATIENT

V - TECS 4
L.A. #2

Admission Date ______ BATH: Self Assist Bed
Classification ______
Diet ______
Diet ______
Diagnosis ______
Surgery ______

Attending Physician(s):

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			Vital signs (T, P, R, and BP) on admission and @ HS prior to surgery and AM of surgery. Prepare for surgery as ordered:	Afebrile (less 99.6) 12 hours prior to surger Establishment of baseline vital signs.
			Up ad lib unless contraindicated.	Ambulatory
			1. Give verbal and/or written explanation of preparation for surgery and of post-op care.	Verbalizes instructions regarding procedures and coopera with plan of care
			2. Explain operative permit to patient and witness patient's signature.	Informed consent.

FOR: Appendectomy Post ICU Gastrectomy Abdominal Surgery, Adult
Hernia Exploratory Laparptory
Pilonidal Cyst Cholecystectomy

Admission Date ________ BATH: Self Assist Bed

Classification ________

Diet ________

Diet ________

Diagnosis ________

Surgery ________ Page 1

Attending Physician(s):

________ ________

________ ________

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOM
			1.A. Vital signs (T, P, R, and BP) every 4 hrs.	Afebrile (te
			x 72 hours.	less than 99
			B. DC at _____ am/pm on ______________.	24 hrs. pric
			Then routine q __________ hrs.	discharge.
			C. Turn, cough, deep breathe every 2 hrs.	
			x 24 hours.	
			Assist patient to splint incision as	
			necessary.	
			2.A. Check dressing(s) every 4 hrs. x 24, then	Clean healin
			QID	wound.
1/12			"Patient not to have visitors"	
		(Use Red Ink)		
			B. If prn dressing change order:	
			Change dressing at least daily to observe	
			wound area for redness, swelling, increased	
			drainage, healing.	
			C. Note presence of:	
			Drain ____________ Removed ____________	
			Skin clips __________ Remove ____________	
			Staples __________ Remove ____________	
			Sutures __________ Remove ____________	
			Steri-strips ____________	
			T-tube _____ Empty _____ Removed ________	
			Hemovac _____ Empty _____ Removed ________	
			Other ____________	

FOR: Appendectomy Post ICU Gastrectomy Abdominal Surgery, Adult
Hernia Exploratory Laparotory
Pilonidal Cyst Cholecystectomy

Admission Date ____________________ BATH: Self Assist Bed

Classification ____________________

Diet ____________________

[illegible] ____________________

Diagnosis ____________________

Surgery ____________________ Page 1

Attending Physician(s):

________________ ________________

________________ ________________

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOM
			1.A. Vital signs (T, P, R, and BP) every 4 hrs.	Afebrile (te
			x 72 hours.	less than 99
			B. DC at ______ am/pm on ______________.	24 hrs. prio
			Then routine q ____________ hrs.	discharge.
			C. Turn, cough, deep breathe every 2 hrs.	
			x 24 hours.	
			Assist patient to splint incision as	
			necessary.	
			2.A. Check dressing(s) every 4 hrs. x 24, then	Clean healin
			QID	wound.
			B. If prn dressing change order:	
			Change dressing at least daily to observe	
			wound area for redness, swelling, increased	
			drainage, healing.	
			C. Note presence of:	
			Drain ____________ Removed ____________	
			Skin clips __________ Remove ____________	
			Staples ____________ Remove ____________	
			Sutures ____________ Remove ____________	
			Steri-strips ____________________	
			T-tube ______ Empty ______ Removed ____________	
			Hemovac ______ Empty ______ Removed ____________	
			Other ______________________________	

FOR: Appendectomy Post ICU Gastrectomy Abdominal Surgery, Adult
Hernia Exploratory Laparotomy
Pilonidal Cyst Cholecystectomy

Admission Date ____________ BATH: Self Assist Bed

Classification ____________

Diet ____________

Diet ____________

Diagnosis ____________

Surgery ____________ Page 1

Attending Physician(s):

____________ ____________

____________ ____________

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			1.A. Vital signs (T, P, R, and BP) every 4 hrs.	Afebrile (temp.
			x 72 hours.	less than 99.6
			B. DC at _____ am/pm on _____________.	24 hrs. prior
			Then routine q ___________ hrs.	discharge.
			C. Turn, cough, deep breathe every 2 hrs.	
			x 24 hours.	
			Assist patient to splint incision as	
			necessary.	
			2.A. Check dressing(s) every 4 hrs. x 24, then	Clean healing
			QID	wound.
			B. If prn dressing change order:	
			Change dressing at least daily to observe	
			wound area for redness, swelling, increased	
			drainage, healing.	
			C. Note presence of:	
			Drain __________ Removed __________	
			Skin clips __________ Remove __________	
			Staples __________ Remove __________	
			Sutures __________ Remove __________	
			Steri-strips __________	
			T-tube _____ Empty _____ Removed __________	
			Hemovac _____ Empty _____ Removed __________	
			Other __________	

V-TECS 4
L.A. #8

STUDENT ______________________

DATE ______________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Arrange special visiting privileges.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When arranging special visiting privileges, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Verified and posted special visiting privileges.	( )	( )	( )	( )	( )
2. Informed special of hospital policies.	( )	( )	( )	( )	( )
3. Identified and provided for the basic physical needs of the long-term visitor as necessary.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECEPTIONIST ACTIVITIES

TASK: Greet physician and provide patients' charts

PERFORMANCE OBJECTIVE

Given the charts of forty patients with color-coded labels and the physicians' color codes identifying three physicians, greet the physicians and give each the correct patients' charts. All items on the instructor's checklist must be rated "fully accomplished." (4)

PERFORMANCE GUIDE

1. Identify and address each physician by name courteously.
2. Establish nature of visit.
3. Select the correct patients' charts.
4. Check each chart for availability of writing space and completeness of charting.
5. Give the correct charts to the physician, and determine whether any other assistance is needed.
6. Chart the visit of each physician on each of the patients' charts: date and time.

LEARNING ACTIVITIES

1. Discuss color-coding as it relates to patient charts.
2. Read a reputable source on etiquette and compile a list of appropriate greetings.
3. Divide into small groups and rehearse saying the greetings with a pleasant facial expression.
4. Role play in front of the class a situation in which three "physicians" approach a "clerk" who has ten color-coded charts. Act out performance guides 1-6.
5. Perform the items listed on the instructor's checklist until receiving a "fully accomplished" rating.

RESOURCES

books on etiquette

TOOLS AND EQUIPMENT

patient charts (with color-coded labels)

EVALUATION

Using provided information and materials, the student will greet three physicians and provide each with the correct patients' charts.

V-TECS 7
L.A. #5

STUDENT_________________________

DATE___________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Greet physician and provide patients' charts.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When greeting physician and providing patients' charts, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Recognized physician, addressig him/her appropriately in greeting.	( )	( )	( )	( )	( )
2. Selected correct charts.	( )	( )	( )	( )	( )
3. Gave charts to physician courteously.	( )	( )	( )	( )	( )
4. Determined whether any other assistance was needed.	( )	( )	( )	( )	( )
5. Verified identity of physician tactfully (if unknown by ward clerk).	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Initiate and respond to telecom/intercom communications

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PERFORMANCE OBJECTIVE

Given the required information, supplies, telecom or intercom equipment, and three patient signals: respond to the signals, locate personnel, and relay messages. All signals will be responded to within two minutes, messages will be written, and initiated calls will be implemented within two minutes. (4)

PERFORMANCE GUIDE

1. Acknowledge the signal, activate the equipment, identify yourself and offer assistance using a pleasant tone of voice. Caution: Patient signals may indicate any degree of need.
2. Identify patient, recording name, room number, time, and written message on form.
3. Locate the person assigned to this patient via telecom or intercom.
4. Relay the message accurately to the assigned person quickly.
5. If the assigned person is off the unit or otherwise unavailable, request another qualified person to fulfill the patient's request.
6. Seek assistance of the team leader if needed.
7. Report back to the patient promptly via telecom/intercom.

LEARNING ACTIVITIES

1. Demonstrate the use and purpose of the telecom/intercom for each unit.
2. Role play situations involving the use of the telecom/intercom: both in receiving and relaying messages.
3. Distribute and discuss the information sheet titled "Daily Unit Assignment Sheet" (attached), i.e., how and why patients are assigned to nursing personnel.
4. Read aloud the RN/LPN and NA/NT job descriptions (attached) and review the responsibilities of each.
5. Divide into small groups and discuss three hypothetical situations which require knowledge of the appropriate personnel to execute certain tasks.
6. Practice receiving three mock signals on a real telecom/intercom system.
7. Practice relaying three mock messages gleaned from a real telecom/intercom system.
8. List the responsibilities of the RN/LPN, NA/NT as they relate to responding to patient needs expressed via the telecom/intercom system.
9. Show mastery of task (i.e., initiating and responding to telecom/intercom communications) by performing it in a manner acceptable to the instructor.

TOOLS AND EQUIPMENT

telecom/intercom
clock/watch
message pad
writing materials

EVALUATION

Using materials and information provided, the student will answer three patient signals, initiate calls for personnel on telecom/intercom, and relay messages. All signals must be responded to within two minutes; messages must be written accurately and legibly; initiated calls for personnel on telecom/intercom must be executed within two minutes.

DAILY UNIT ASSIGNMENT SHEET

This sheet will be posted on the bulletin board on the unit.

It will be made for each of the three (3) shifts daily.

DATE: Present

CHARGE NURSE or NURSE CLINICIAN will make out this sheet.

UNIT DIVIDED: Nurses and assistants from room numbers to room numbers.

LEARN: Intercom-answer to care for patient's need(s).
Be sure to know the patient's room number, name and the need(s) - then tell appropriate person assigned to the patient to take care of the need(s).

Telephone: on the unit -- identify unit, self and title.

V-TECS 53
L.A. #3

DATE	**DAILY UNIT ASSIGNMENT SHEET**	SHIFT

Charge Nurse	Break: Meal:	Ward Clerk	Break: Meal:
Group I	Rooms	Group II	Rooms
Leader: Meeting:	Break: Meal:	Leader: Meeting:	Break: Meal:
Member: Meeting:	Break: Meal: Duty:	Member: Meeting:	Break: Meal: Duty:
Member: Meeting:	Break: Meal: Duty:	Member: Meeting:	Break: Meal: Duty:
Member: Meeting:	Break: Meal: Duty:	Member: Meeting:	Break: Meal: Duty:

Nursing Rounds Time:	Nursing Rounds Time:
Nursing Care Planning Conference	Nursing Care Planning Conference
Time: Patient:	Time: Patient:
Topic:	Topic:
Participants:	Participants:
Suggestions:	Suggestions:

The following performance criteria have been identified as expected and above expected for the Nursing Assistant. Circle the number of each criterion met. Criteria are considered to be self explanatory and met consistently unless otherwise specified. The supervisor may ask for evidence of having met any of the expected or above expected criteria.

1.0 POLICIES

Expected

1. 1 Reports to work as scheduled.

1. 2 Clocks in and out on time card correctly.

1. 3 Uses correct procedure for notification of illness.

1. 4 Signs time card every pay period.

1. 5 Seeks approval from Nurse Clinician for scheduled overtime.

1. 6 Cooperates when time schedules must be altered.

1. 7 Uses correct procedure for changing work schedule.

1. 8 Wears name pin so that it is clearly visible at all times.

1. 9 Wears correct attire for area.

1.10 Maintains personal hygiene and cleanliness.

1.11 Knows where to locate and uses Nursing Service Manuals.

1.12 Knows where to locate and uses Administrative Manuals.

1.13 Knows where to locate and uses other department manuals.

1.14 Conforms to any other Nursing Service and hospital policies.

2.0 NURSING PROCESS

Expected

2.1 Observes condition of all patients on unit (assigned and other) whenever contact is made and reports abnormalities or pertinent observations to the appropriate nurse.

2.2 Asks pertinent questions regarding patient care assignment when appropriate.

2.3 Plans and completes assignment in a timely manner.

2.4 Participates in and contributes to conferences for planning patient care.

Above Expected

2.1 Communicates less obvious or potential problems regarding the patient to the appropriate nurse.

2.2 Provides pertinent information and suggestions which will contribute to plan of care.

2.3 Asks appropriate questions which stimulates discussion and/or leads to conference topics.

2.4 Reinforces patient and family teaching when appropriate.

3.0 DOCUMENTATION OF PATIENT CARE ON PATIENT CARE RECORD

Expected

3.1 Uses full name and title in all signatures.

3.2 Uses approved and appropriate abbreviations.

3.3 Completes forms as described in charting section of Nursing Service Manuals and/or Consent Manual.

Above Expected

3.1 Assists with revision of existing forms and development of new forms.

4.0 CLINICAL SKILLS

4. 1 Takes routine T, P, R, and BP.

4. 2 Passes fresh drinking water at least two times on the AM and PM tour of duty and PRN and on the night tour PRN.

4. 3 Prepares patient for meals: a. Positions patient. b. Allows patient to wash face and hands before and after meals. c. Allows patient to brush teeth as desired. d. Cuts meat, opens milk, etc., as necessary.

4. 4 Feeds patients as necessary.

4. 5 Provides bath for patients: a. Gives complete bed bath. b. Assists with bath including pericare PRN. c. Gives bath water at bedside. d. Runs tub water. e. Assists with shower.

4. 6 Assists with sitz bath.

4. 7 Gives back rubs.

4. 8 Gives mouth care or provides for mouth care.

4. 9 Assists patient in putting on clean bed clothes.

4.10 Combs patient's hair as needed.

4.11 Makes bed.

4.12 Gives clean washcloth and towel to patients.

4.13 Arranges patient's unit: a. Cleans bedside table. b. Picks up articles on floor in room and bathroom. c. Makes room neat and clean in appearance. d. Removes excess cups, dishes, linens, etc..

4.14 Adjusts patient's bed.

4.15 Lifts, moves, and turns patient correctly.

4.16 Assist patients with wheelchairs.

4.17 Assist patients to walk.

4.18 Assist patients to cough, turn, deep breathe as assigned.

4.19 Answers signal lights and responds appropriately.

4.20 Prepares unit for post-up patients: a. Secures IV pole. b. Has bed in high position. c. Has side rails on bed.

4.21 Measures oral fluid intake as assigned.

4.22 Measures output: foley catheter drainage, voided urine, emesis and liquid stool.

4.23 Records intake and output on bedside I & O worksheet.

4.24 Strains urine.

4.25 Collects urine specimens for the following: a. S & A's. b. Routine urinalysis: voided, midstream, clean catch. c. 24 hour urine and keeps on ice when necessary. d. Glucose tolerance test.

4.26 Collects stool specimens (other than from colostomy).

4.27 Assists with the following procedures: H & P exams, vaginal exams, and rectal exams.

4.28 Assists with admissions, transfers, and discharging of patients.

4.29 Gives immediate assistance to other departments with transfer of patients to and from wheelchair or stretcher.

4.30 Assist patients to bathroom, bedside commode and/or with urinal or bedpan.

4.31 Empties and cleans utensils after each use.

4.32 Applies warming unit and maintains correct temperature.

4.33 Applies hot and cold compresses, ice bags and/or collars and refills as necessary.

4.34 Gives enemas and/or douches according to Nursing Service Manual.

4.35 Carries out isolation procedures.

4.36 Removes and reapplies anti-embolism hose as assigned.

4.37 Cares for body after death.

4.38 Takes appropriate slips to other areas in the hospital as assigned, and picks up supplies and/or equipment as assigned.

4.39 Assists with emergency procedures: CPR, fire, and disaster.

4.40 Cleans and returns equipment to proper place.

4.41 Applies restraints.

4.42 Applies male external catheter.

4.43 Performs male urethral catheterization and removes as assigned.

Above Expected

4.1 Utilizes available resources when unfamiliar with a procedure or skill.

4.2 Operates equipment or instruments not routinely used on the unit utilizing Nursing Service Manual.

4.3 Demonstrates interest in learning new skills and procedures.

5.0 WORKING WITH OTHERS

Expected

5. 1 Maintains a positive attitude and receives no valid complaints regarding attitude or behavior.

5. 2 Communicates change and implements change cooperatively.

5. 3 Communicates with patients, families, unit personnel, physicians and personnel of other departments in courteous and professional manner.

5. 4 Discusses problems or complaints with immediate supervisor.

5. 5 Identifies when co-workers need assistance and offers help. Cooperates willingly with co-workers in completing heavy work assignments.

5. 6 Works effectively with unit personnel, students, instructors, interns, and other new employees.

5. 7 Reports verbally significant observations regarding performance of staff members to Nurse Clinician or Charge Nurse as requested.

Above Expected

5. 1 Identifies negative feelings and discusses them with Nurse Clinician or other appropriate person.

5. 2 Identifies the need for change and possible ways to implement it in writing.

5. 3 Demonstrates effective communication through written or verbal feedback from patient, families, unit personnel, physicians, and personnel of other departments.

5. 4 Offers solutions to problems or identifies means of handling complaints in writing to immediate supervisor.

5. 5 Identifies things that need to be done on the unit and does them without being asked.

5. 6 Seeks ways to provide learning experiences for students, interns, and other new employees. Gives written and/or verbal feedback regarding student's interns', and other employees' performance to immediate supervisor.

5. 7 Assists Nurse Clinician in evaluation of staff members when requested.

5. 8 Gives written anecdotal notes regarding co-workers' performance to Nurse Clinician.

6.0 SELF-DEVELOPMENT

Expected

6. 1 Completes written self-evaluation according to job description yearly and includes goals for self-development.

6. 2 Attends and participates in the Staff Development programs held at the Hospital. Must attend all mandatory classes.

6. 3 Attends and participates in unit meetings/conferences. When absent, reads, and initials minutes.

6. 4 Reads and initials all new policies, procedures, memorandums and notations in communication book or on clipboard.

6. 5 Shares with staff information gained at hospital sponsored workshops and documents.

6. 6 Assists with orientation of new nursing personnel as assigned by Nurse Clinician.

Above Expected

6. 1 Schedules periodic self-evaluation conferences with Nurse Clinician to assess progress in attaining goals and documents.

6. 2 Seeks out informal evaluation by peer group and other members of nursing staff and documents.

6. 3 Reads selection from health care literature on a monthly basis and documents quarterly.

6. 4 Posts pertinent articles from health care literature on unit once per quarter. Must document title of article, source and date posted.

6. 5 Volunteers to be an orientation preceptor and assists with completion of skills inventory checklist.

6. 6 Makes written recommendations for unit orientation outline.

JOB DESCRIPTION/PERFORMANCE EVALUATION

TITLE:	NURSING TECHNICIAN
DEPARTMENT:	Nursing Service
QUALIFICATIONS:	N.T. I -- Currently enrolled in a program of Nursing and has satisfactorily completed a course in Nursing Fundamentals or has satisfactorily completed a Nursing Technician Course. N.T. II -- Graduate of a program in Nursing who fails to satisfactorily complete the State Board Test Pool Examination upon first time writing.
JOB SUMMARY:	Assists in providing nursing care to patients.
SUPERVISOR:	Nurse Clinician or Assistant Director of Nursing for Evenings and Nights

☐ Expected - Meets all of 1.0 Policies (14 criteria) plus eighty percent (80%) (67 criteria) of the expected criteria in sections 2.0 - 6.0.

☐ Above Expected - Meets all of the expected criteria (98 criteria) plus forty percent (40%) of the above expected criteria (9 criteria)

☐ Outstanding - Meets all of the expected criteria (98 criteria) plus eighty percent (80%) of the above expected criteria (18 criteria)

Meets criteria for annual merit increase due to no disciplinary action beyond verbal counseling.

Date of Evaluation ______________________________

Signature of Evaluator ___________________________

Signature of Evaluatee ___________________________

Signature of Reviewer ___________________________

Comments ______________________________________

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The following performance criteria have been identified as expected and above expected for the Nursing Technician. Circle the number of each criterion met. Criteria are considered to be self explanatory and met consistently unless otherwise specified. The supervisor may ask for evidence of having met any of the expected or above expected criteria.

1.0 POLICIES

Expected

1. 1 Reports to work as scheduled.

1. 2 Clocks in and out on time card correctly.

1. 3 Uses correct procedure for notification of illness.

1. 4 Signs time card every pay period.

1. 5 Seeks approval from Nurse Clinician for scheduled overtime.

1. 6 Cooperates when time schedules must be altered.

1. 7 Uses correct procedure for changing work schedule.

1. 8 Wears name pin so that it is clearly visible at all times.

1. 9 Wears correct attire for area.

1.10 Maintains personal hygiene and cleanliness.

1.11 Knows where to locate and uses Nursing Service Manuals.

1.12 Knows where to locate and uses Administrative Manuals.

1.13 Knows where to locate and uses other department manuals.

1.14 Conforms to any other Nursing Service and hospital policies.

2.0 NURSING PROCESS

Expected

2. 1 Interviews patient on admission and reports pertinent information to appropriate nurse.

2. 2 Observes condition of all patients on unit (assigned and other) whenever contact is made and reports abnormalities or pertinent observations to appropriate nurse.

2. 3 Asks pertinent questions which stimulates discussion and/or leads to conference topic.

2. 4 Participates in and contributes to conferences for planning patient care.

2. 5 Confers with nurse in charge regarding patient care assignment and asks pertinent questions regarding assignments at appropriate time.

2. 6 Informs nurse in charge of learning needs as well as personal preferences and abilities regarding assignments as appropriate.

2. 7 Provides pertinent information and suggestions which contribute to plan of care.

2. 8 Implements physical, psychosocial, and teaching components of patient care, identified in care plan, according to established standard.

Above Expected

2. 1 Utilizes assessment tools to identify patient problems, needs and interventions.

2. 2 Communicates less obvious or potential problems regarding the patient to the appropriate nurse.

3.0 DOCUMENTATION OF PATIENT CARE ON PATIENT CARE RECORD

Expected

3. 1 Uses full name and title in all signature.

3. 2 Uses approved and appropriate abbreviations.

3. 3 Documents information in chronological order, at the time of the event or observation, with the time and date included.

3. 4 Documents and signs those events personally performed or observed.

3. 5 Documents in a clear, concise, accurate and legible manner.

3. 6 Selects and initiates appropriate forms at the proper time(s) after consulting with appropriate nurse.

3. 7 Completes forms as described in charting section of Nursing Service Manuals and/or Consent Manual.

Above Expected

3. 1 Assists with revision of existing forms or development of new forms.

3. 2 Assists with the change process involved in implementing new forms on the unit.

4.0 CLINICAL SKILLS

4. 1 Takes routine T,P,R and BP.

4. 2 Passes fresh drinking water at least two times on the AM and PM tour of duty and PRN and on the night tour PRN.

4. 3 Prepares patient for meals: a. Positions patient. b. Allows patient to wash face and hands before and after meals. Allows patient to brush teeth as desired. d. Cuts meat, opens milk, etc. as necessary.

4. 4 Feeds patients as necessary.

4. 5 Provides bath for patients: a. Gives complete bed bath. b. Assists with bath including pericare PRN. c. Gives bath water at bedside. d. Runs tub water. e. Assists with shower.

4. 6 Assists with sitz bath.

4. 7 Give back rubs.

4. 8 Gives mouth care or provides for mouth care.

4. 9 Assists patient in putting on clean bed clothes.

4.10 Combs patient's hair as needed.

4.11 Makes bed.

4.12 Gives clean wash cloth and towel to patients.

4.13 Arranges patient's unit: a. Cleans bedside table. b. Picks up articles on floor in room and bathroom. c. Makes room neat and clean in appearance. d. Removes excess cups, dishes, linens, etc.

4.14 Adjusts patient's bed.

4.15 Lifts, moves, and turns patient correctly.

4.16 Assist patients with wheelchairs.

4.17 Assist patients to walk.

4.18 Assists patients to cough, turn, deep breathe as assigned.

4.19 Answers signal lights and responds appropriately.

4.20 Prepares unit for post-up patients: a. Secures IV pole. b. Has bed in high position. c. Has side rails on bed.

4.21 Measures oral fluid intake as assigned.

4.22 Measures output: foley catheter drainage, voided urine, emesis and liquid stool.

4.23 Records intake and output on bedside I & O worksheet.

4.24 Strains urine.

4.25 Collects urine specimens for the following: a. Routine urinalysis: voided, midstream, clean catch b. 24 hour urine and keeps on ice when necessary c. Glucose tolerance test d. S & A's and completes the test, cultures.

4.26 Collect stool specimens (other tnan from colostomy).

4.27 Assists with the following procedures: vaginal exams, rectal exams, H & P exams, pelvic exams, bone marrow aspiration or biopsy, abdominal paracentesis, thoracentesis, liver biopsy, lumbar puncture, pap smears, lacerations, and endoscopy procedures.

4.28 Assists with admission, transfers, and discharging of patients.

4.29 Gives immediate assistance to other departments with transfer of patients to or from wheelchair or stretcher.

4.30 Assist patients to bathroom, bedside commode and/or with urinal or bedpan.

4.31 Empties and cleans utensils after each use.

4.32 Applies warming unit and maintains correct temperture.

4.33 Applies hot and cold compresses, sterile and non-sterile ice bags and/or collars and refills as necessary.

4.34 Gives enemas and/or douches according to Nursing Service Manual.

4.35 Carries out isolation procedures.

4.36 Removes and reapplies anti-embolism hose as assigned.

4.37 Cares for body after death.

4.38 Takes appropriate slips to other areas in the hospital as assigned, and picks up supplies and/or equipment as assigned.

4.39 Assists with emergency procedures: CPR, fire, and disaster.

4.40 Cleans and returns equipment to proper place.

4.41 Applies restraints.

4.42 Performs the procedure for sterile glove and open glove technique.

4.43 Changes dressings according to Nursing Service Manual. (Refer to NSM for exceptions)

4.44 Removes staples, sutures, and skin clips.

4.45 Prepares sterile trays for procedures.

4.46 Applies male external catheter.

4.47 Performs male and/or female urethral catheterization and removes.

4.48 Applies binders (abdominal and breast).

4.49 Uses bed scales.

4.50 Uses Hoyer lift.

4.51 Uses footboard.

4.52 Uses K-thermia equipment.

4.53 Uses air mattress.

4.54 Uses peri lamp.

4.55 Measures and empties Gomco, hemovacs, Reliavacs and Jackson Pratt drainage systems and T-tubes.

4.56 Performs other selected measures learned in school and checked off by the Nurse Clinician for competency.

Above Expected
4. 1 Utilizes available resources when unfamiliar with a procedure or skill.

4. 2 Operates equipment or instruments not routinely used on the unit utilizing Nursing Service Manual.

4. 3 Demonstrates interest in learning new skills and procedures.

5.0 WORKING WITH OTHERS

Expected

5. 1 Maintains a positive attitude and receives no valid complaints regarding attitude or behavior.

5. 2 Communicates change and implements change cooperatively.

5. 3 Communicates with patients, families, unit personnel, physicians and personnel of other departments in courteous and professional manner.

5. 4 Discusses problems or complaints with immediate supervisor.

5. 5 Identifies when co-workers need assistance and offers help. Cooperatives willingly with co-workers in completing heavy work assignments.

5. 6 Works effectively with unit personnel, students, instructors, interns and other new employees.

5. 7 Reports verbally significant observations regarding performance of staff members to Nurse Clinician or Charge Nurse.

Above Expected

5. 1 Identifies negative feelings and discusses them with Nurse Clinician or other appropriate person.

5. 2 Identifies the need for change and possible ways to implement it in writing.

5. 3 Demonstrates effective communication through written or verbal feedback from patients, families, unit personnel, physicians, and personnel of other departments.

5. 4 Offers solutions to problems or identifies means of handling complaints in writing to immediate supervisor.

5. 5 Identifies things that need to be done on the unit and does them without being asked.

5 6 Seeks ways to provide learning experiences for students, interns, and other new employees. Gives written and/or verbal feedback regarding students', interns', and other employees' performance to immediate supervisor.

5 7 Assist Nurse Clinician in evaluation of staff members when requested.

5 8 Gives written anecdotal notes regarding co-workers performance to Nurse Clinician.

6.0 **SELF-DEVELOPMENT**

Expected

6 1 Completes written self-evaluation according to job description yearly and includes goals for self-development.

6 2 Attends and participates in the Staff Development program held at the hospital. Must attend all mandatory classes.

6 3 Attends and participates in unit meetings/conferences. When absent, reads, and initials minutes.

6 4 Reads and initials all new policies, procedures, memorandums and notations in communication book or on clipboard.

6 5 Shares with staff information gained at hospital sponsored workshops and documents.

6 6 Assists with orientation of new nursing personnel as assigned by Nurse Clinician.

Above Expected

6 1 Schedules periodic self-evaluation conferences with Nurse Clinicans to assess progress in attaining goals and documents.

6 2 Seeks out informal evaluation by peer group and other members of nursing staff and documents.

6 3 Reads selection from health care literature on a monthly basis and documents quarterly.

6 4 Posts pertinent articles from health care literature on unit once per quarter. Must document title of article, source and date posted.

6 5 Conducts or coordinates one unit inservice per year based on learning needs of unit. Documents date held, topic, and attendance.

6. 6 Shares with staff information gained at workshops attended on own time and/or own expense and documents.

6. 7 Volunteers to be an orientation preceptor and assists with completion of skills inventory checklist.

6. 8 Makes written recommendations for unit orientation outline.

JOB DESCRIPTION/PERFORMANCE EVALUATION

TITLE: CLINICAL NURSE I - LPN

DEPARTMENT: Nursing Service

QUALIFICATIONS: Currently licensed as a Practical Nurse by the State Board of Nursing of South Carolina

JOB SUMMARY: Performs selected activities in caring for patients under the direction of a registered professional nurse.

SUPERVISOR: Nurse Clinician and/or Assistant Director of Nursing for Evenings and Nights

☐ Expected - Meets all of 1.0 Policies (15 criteria) plus eighty percent (80%) (28 criteria) of the expected criteria in sections 2.0 - 6.0.

☐ Above Expected - Meets all of the expected criteria (53 criteria) plus forty percent (40%) of the above expected criteria (14 criteria)

☐ Outstanding - Meets all of the expected criteria (53 criteria) plus eighty percent (80%) of the above expected criteria (29 criteria)

Meets criteria for annual merit increase due to no disciplinary action beyond verbal counseling.

Date of Evaluation ______________________________

Signature of Evaluator ______________________________

Signature of Evaluatee ______________________________

Signature of Reviewer ______________________________

Comments ____

____

____

BEST COPY AVAILABLE

The following performance criteria have been identified as expected and above expected for the Clinical Nurse I. Circle the number of each criterion met. Criteria are considered to be self explanatory and met consistently unless otherwise specified. The supervisor may ask for evidence of having met any of the expected or above expected criteria.

1.0 POLICIES

Expected

1. 1 Reports to work as scheduled.

1. 2 Clocks in and out on time card correctly.

1. 3 Uses correct procedure for notification of illness.

1. 4 Signs time card every pay period.

1. 5 Seeks approval from Nurse Clinician for scheduled overtime.

1. 6 Cooperates when time schedule must be altered.

1. 7 Uses correct procedure for changing work schedule.

1. 8 Wears name pin so that it is clearly visible at all times.

1. 9 Wears correct attire for area.

1.10 Maintains personal hygiene and cleanliness.

1.11 Knows where to locate and uses Nursing Service Manuals.

1.12 Knows where to locate and uses Administrative Manuals.

1.13 Knows where to locate and uses other department manuals.

1.14 Conforms to any other Nursing Service and hospital policies.

1.15 Provides Nursing Service with a copy of license renewal certificate on an annual basis prior to expiration date.

2.0 NURSING PROCESS

Expected

2. 1 Utilizes assessment tools to identify patient problems, needs and interventions.

2. 2 Individualizes and maintains a written plan of care revising as needed. Consults nurse in charge for assistance if patient has multiple problems or no standardized care plan available.

2.3 Participates in and contributes to conferences for planning patient care.

2. 4 Implements physical, psychosocial, and teaching components of patient care, identified in the care plan, according to established standards.

2. 5 Confers with nurse in charge regarding patient care assignment and asks pertinent questions regarding assignments at appropriate time.

2. 6 Utilizes nursing skills to identify patient problems and illnesses and confers with nurse in charge.

2. 7 Recognizes changes in signs, symptoms, and results of diagnostic studies and reports to charge nurse.

2. 8 Provides pertinent information and suggestions which contributes to plan of care.

Above Expected

2. 1 Utilizes family and interdisciplinary personnel to implement the plan of care.

2. 2 Includes in care plan significant potential patient problems based on input from patient and family.

2. 3 Observes less obvious changes in patient's condition and reports to charge nurse.

2. 4 Initiates impromptu patient care conferences. Writes summary and documents attendance.

2. 5 Initiates scheduled conferences on patient care or current health care trends. Writes summary and documents attendance.

2. 6 Participates in reviewing and revising audit criteria (process or outcome), or standard care plans.

2. 7 Teaches patients, as individuals and/or groups, on a level they can understand utilizing teaching resources available.

3.0 DOCUMENTATION OF PATIENT CARE ON PATIENT CARE RECORD

Expected

3. 1 Uses full name and title in all signatures.

3. 2 Documents information in chronological order, at the time of the event or observation, with the time and date included.

3. 4 Documents and signs those events personally performed or observed.

3. 5 Documents in a clear, concise, accurate and legible manner.

3. 6 Documents all the necessary information to communicate the patient's progress.

3. 7 Selects and initiates appropriate forms at appropriate time(s).

3. 8 Completes forms as described in charting section of Nursing Service Manuals and/or Consent Manual.

Above Expected

3. 1 Revises existing forms and submits to appropriate committee or resource.

3. 2 Develops new forms and submits to appropriate committee or resource.

3. 3 Assists with the change process involved in implementing new forms on the unit.

4.0 CLINICAL SKILLS

Expected

4. 1 Provides personal hygiene for patient.

4. 2 Administers medications according to Nursing Service Manuals.

4. 3 Administers parenteral therapy according to Nursing Service Manuals.

4. 4 Carries out physician's orders accurately and questions unclear orders.

4. 5 Performs treatments and procedures according to Nursing Service Manuals.

4. 6 Maintains supplies and equipment.

4. 7 Initiates and carries out appropriate emergency codes.

4. 8 Initiates nurse-physician communication as appropriate.

Above Expected

4. 1 Recognizes potential for skin breakdown and institutes care.

4. 2 Recognizes need for and requests changes in physician orders after consultation with charge nurse.

4. 3 Recognizes potential adverse symptoms to parenteral therapy and notifies physician after consultation with charge nurse.

4. 4 Exhibits clinical expertise and/or utilizes skills of others in performance of treatments and procedures.

4. 5 Projects future supply needs by written reports on quantities and qualities of equipment.

4. 6 Recognizes potential benefits of selected new products and discusses with supervisor possible acquisition for use.

4. 7 Documents in writing the specifics of performance during codes and conveys this information to Nurse Clinician.

4. 8 Prepares for nurse-physician rounds.

4. 9 Assist in facilitating patient-physician-nurse communication process.

5.0 WORKING WITH OTHERS

Expected

5. 1 Maintains a positive attitude and receives no valid complaints regarding attitude or behavior.

5. 2 Communicates change and implements change cooperatively.

5. 3 Communicates with patients, families, unit personnel, physicians and personnel of other departments in courteous and professional manner.

5. 4 Discusses problems or complaints with immediate supervisor.

5. 5 Identifies when co-workers need assistance and offers help. Cooperates willingly with co-workers in completing heavy work assignments.

5 6 Works effectively with unit personnel, students, instructors, interns and other new employees.

5. 7 Gives verbal feedback regarding co-workers performance and performance of personnel from other areas to immediate supervisor.

Above Expected

5. 1 Identifies negative feelings and discusses them with Nurse Clinician or other appropriate person.

5. 2 Identifies the need for change and possible ways to implement it in writing.

5. 3 Demonstrtes effective communication through written or verbal feedback from patients, families, unit personnel, physicians, and personnel of other departments.

5. 4 Offers solutions to problems or identifies means of handling complaints in writing to immediate supervisor.

5. 5 Identifies things that need to be done on the unit and does them without being asked.

5. 6 Seeks ways to provide learning experiences for unit personnel, students, interns, and other new employees. Gives written and/or verbal feedback regarding students', interns', and other new employees' performance to immediate supervisor.

5. 7 Assists immediate supervisor with evaluation of staff members when requested.

6.0 SELF-DEVELOPMENT

Expected

6. 1 Completes written self-evaluation according to job description one month prior to annual due date and submits to immediate supervisor. Includes goals for self-evaluation.

6. 2 Reads selection from health care literature on a monthly basis and documents quarterly.

6. 3 Attends and participates in the Staff Development programs held at the hospital. Must attend all mandatory classes.

6. 4 Attends and participates in unit meetings/conferences. When absent, reads and initials minutes.

6. 5 Reads and initials all new policies, procedures, memorandums and notations in communication book or on clipboard.

6. 6 Shares with staff information gained at hospital sponsored workshops and documents.

6. 7 Assists with orientation of new nursing personnel as assigned by Nurse Clinician.

Above Expected

6. 1 Schedules periodic self-evaluation conferences with Nurse Clinicians to assess progress in attaining goals and documents.

6. 2 Seeks out informal evaluation by peer group and other members of nursing staff and documents.

6. 3 Develops individual evaluation tools and distributes to peer group and other members of nursing staff for formal evaluation.

6. 4 Post pertinent articles from health care literature on unit once per quarter. Must document title of article, source and date posted.

6. 5 Conducts or coordinates one unit inservice per year based on learning needs of unit. Documents date held, topic, and attendance.

6. 6 Participates in planning and/or presentation of an educational offering sponsored by Nursing Staff Development and/or Hospitalwide Education Department.

6. 7 Shares with staff information gained at workshops attended on own time and/or own expense and documents.

6. 8 Volunteers to be an orientation preceptor and assists with completion of skills inventory checklist.

6. 9 Makes written recommendations for unit orientation outline.

6.10 Demonstrates continued professional growth through participation in professional organizations, continuing formal education, etc..

V-TECS 53
L.A. #4

JOB DESCRIPTION/PERFORMANCE EVALUATION

TITLE: CLINICAL NURSE II - RN

DEPARTMENT: Nursing Service

QUALIFICATIONS: Currently licensed as a registered nurse by the State Board of Nursing for South Carolina.

JOB SUMMARY: Paticipates in planning, implementing, and evaluating nursing care for all classifications of patients as assigned. May act in lieu of Nurse Clinician as assigned.

SUPERVISOR: Nurse Clinician and/or Assistant Director of Nursing for Evenings and Nights.

☐ Expected - Meets all of 1. 0 Policies (15 criteria) plus eighty percent (80%) (31 criteria) of the expected criteria in sections 2.0 - 6.0.

☐ Above Expected - Meets all of the expected criteria (54 criteria) plus forty percent (40%) of the above expected criteria (16 criteria)

☐ Outstanding - Meets all of the expected criteria (54 criteria) plus eighty percent (80%) of the above expected critoria (31 criteria)

Meets criteria for annual merit increase due to no disciplinary action beyond verbal counseling.

Date of Evaluation ______________________________

Signature of Evaluator ______________________________

Signature of Evaluatee ______________________________

Signature of Reviewer ______________________________

Promoted to Clinical Nurse III _____ Yes _____ No

Job Description for Clinical Nurse III reviewed. Date __________

Comments ______________________________

____

V-TECS 53
L.A. #4

The following performance criteria have been identified as expected and above expected for the Clinical Nurse II. Circle the number of each criterion met. Criteria are considered to be self explanatory and met consistently unless otherwise specified. The supervisor may ask for evidence of having met any of the expected or above expected criteria.

1.0 POLICIES

1. 1 Reports to work as scheduled.

1. 2 Clocks in and out on time card correctly.

1. 3 Uses correct procedure for notification of illness.

1. 4 Signs time card every pay period.

1. 5 Seeks approval from Nurse Clinician for scheduled overtime.

1. 6 Cooperates when time schedule must be altered.

1. 7 Uses correct procedure for changing work schedule.

1. 8 Wears name pin so that it is clearly visible at all times.

1. 9 Wears correct attire for area.

1.10 Maintains personal hygiene and cleanliness.

1.11 Knows where to locate and uses Nursing Service Manuals.

1.12 Knows where to locate and uses Administrative Manuals.

1.13 Knows where to locate and uses other department manuals.

1.14 Conforms to any other Nursing Service and Hospital policies.

1.15 Provides Nursing Service with a copy of license renewal certificate on an annual basis prior to expiration date.

2.0 NURSING PROCESS

Expected

2. 1 Utilizes assessment skills and tools to identify patient problems, needs and interventions.

2. 2 Individualizes and maintains a written plan of care revising as needed.

2. 3 Participates in and contributes to conferences for planning patient care.

2. 4 Implements physical, psychosocial, and teaching components of patient care, identified in the care plan, according to established standards.

2. 5 Utilizes family and interdisciplinary personnel to implement the plan of care.

2. 6 Recognizes patient's and family's need for instruction and takes appropriate action.

2. 7 Sets priorities for action based on problem solving process, common sense, and meeting patient care priorities.

2. 8 Recognizes changes in signs, symptoms, and results of diagnostic studies and responds appropriately.

Above Expected

2. 1 Includes in care plan significant potential patient problems based on input from patient and family.

2. 2 Detects subtle changes in patient's condition and takes appropriate action.

2. 3 Initiates impromptu patient care conferences. Writes summary and documents attendance.

2. 4 Initiates scheduled conferences on patient care or current health care trends. Writes summary and documents attendance.

2. 5 Utilizes personnel's work assignment to develop special abilities of individuals and meet special needs of patients.

2. 6 Participates in reviewing and revising audit criteria or standard care plans.

2. 7 Writes revised or new audit criteria, procedure, care plan, or assessment tools and presents to appropriate committee.

2. 8 Teach patients as individuals and/or groups on level they can understand utilizing teaching resources available.

3.0 DOCUMENTATION OF PATIENT CARE ON PATIENT CARE RECORD

Expected

3. 1 Uses full name and title in all signatures.

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3. 2 Uses approved and appropriate abbreviations.

3. 3 Documents information in chronological order, at the time of the event or observation, with the time and date included.

3. 4 Documents and signs those events personally performed or observed.

3. 5 Documents in a clear, concise, accurate and legible manner.

3. 6 Documents all the necessary informtion to communicate the patient's progress.

3. 7 Selects and initiates appropriate forms at appropriate time(s).

3. 8 Completes forms as described in charting section of Nursing Service Manuals and/or Consent Manual.

Above Expected

3. 1 Revises existing forms and submits to appropriate committee or resource.

3. 2 Develops new forms and submits to appropriate committee or resource.

3. 3 Assists with the change process involved in implementing new forms on the unit.

4.0 CLINICAL SKILLS

Expected

4. 1 Provides personal hygiene for patient.

4. 2 Administers medications according to Nursing Service Manuals.

4. 3 Administers parenteral therapy according to Nursing Service Manuals.

4. 4 Carries out physician's orders accurately and questions unclear orders.

4. 5 Performs treatments and procedures according to Nursing Service Manuals.

4. 6 Maintains supplies and equipment.

4. 7 Initiates and carries out appropriate emergency codes.

4. 8 Initiates nurse-physician communication process.

Above Expected

4. 1 Recognizes potential for skin breakdown and institutes care.

4. 2 Recognizes need for and requests changes in physician orders.

4. 3 Recognizes potential adverse symptoms to parenteral therapy and notifies physician.

4. 4 Utilizes skills of others in performance of treatments and procedures.

4. 5 Projects future supply needs by written reports on quantities and qualities of equipment.

4. 6 Recognizes potential benefits of selected new products and discusses with supervisor possible acquisition for use.

4. 7 Documents in writing the specifics of performance during codes and conveys this information to Nurse Clinician.

4. 8 Prepares for nurse-physician rounds.

4. 9 Assist in facilitating patient-physician-nurse communication process.

5.0 WORKING WITH OTHERS

Expected

5. 1 Maintains a positive attitude and receives no valid complaints regarding attitude or behavior.

5. 2 Communicates change and implements change cooperatively.

5. 3 Communicates with patients, families, unit personnel, physicians, and personnel of other departments in courteous and professional manner.

5. 4 Discusses problems or complaints with immediate supervisor.

5. 5 Identifies when co-workers need assistance and offers help. Cooperates willingly with co-workers in completing heavy work assignments.

5. 6 Works effectively with unit personnel, students, instructors, interns, and other new employees.

5. 7 Accepts the responsibility when designated as Charge Nurse utilizing the units "Charge Nurse Responsibilities" as guidelines.

5. 8 Gives verbal feedback regarding co-workers performance or performance of personnel from other areas to immediate supervisor.

Above Expected

5. 1 Identifies negative feelings and discusses them with Nurse Clinician or other appropriate person.

5. 2 Identifies the need for change and possible ways to implement it in writing.

5. 3 Demonstrates effective communication through written or verbal feedback from patients, families, unit personnel, physicians, and personnel of other departments.

5. 4 Offers solutions to problems or identifies means of handling complaits in writing to immediate supervisor.

5. 5 Identifies things that need to be done on the unit and does them without being asked.

5. 6 Seeks ways to provide learning experiences for unit personnel, students, interns, and other new employees. Gives written and/or verbal feedback regarding students', interns', and new employees' performance to immediate supervisor.

5. 7 Gives Nurse Clinicians written feedback regrding activities on the unit during her tour of duty.

5. 8 Writes and/or reviews evaluation of staff members at discretion of immediate supervisor.

5. 9 Gives written anecdotal notes regarding co-workers' performance or performance of personnel from other areas to immediate supervisor.

6.0 **SELF-DEVELOPMENT**

Expected

6. 1 Completes written self-evaluation according to job description one month prior to annual due date and submits to immediate supervisor. Includes goals for self-evaluation.

6. 2 Reads selection from health care literature on a monthly basis and documents quarterly.

6. 3 Attends and participates in the Staff Development programs held at the hospital. Must attend all mandatory classes.

6. 4 Attends and participates in unit meetings/conferences. When absent, reads and initials minutes.

6. 5 Reads and initials all new policies, procedures, memorandums and notations in communication book or on clipboard.

6. 6 Shares with staff information gained at hospital sponsored workshops and documents.

6. 7 Assists witn orientation of new nursing personnel as assigned by Nurse Clinician.

Above Expected

6. 1 Schedules periodic self-evaluation conferences with Nurse Clinicians to assess progress in attaining goals and documents.

6. 2 Seeks out informal evaluation by peer group and other members of nursing staff and documents.

6. 3 Develops individual evaluation tools and distributes to peer group and other members of nursing staff for formal evaluation.

6. 4 Post pertinent articles from health care literature on unit once per quarter. Must document title of article, source and date posted.

6. 5 Conducts or coordinates one unit inservice per year based on learning needs of unit. Documents date held, topic, and attendance.

6. 6 Participates in planning and/or presentation of an educational offering sponsored by Nursing Staff Development and/or Hospitalwide Education Department.

6. 7 Shares with staff information gained at workshops attended on own time and/or own expense and documents.

6. 8 Volunteers to be an internship or orientation preceptor and assists with completion of skills inventory checklist.

6. 9 Makes written recommendations for unit orientation outline.

6.10 Demonstrates continued professional growth through participation in professional organizations, continuing formal education, etc..

V-TECS 53
L.A. #9

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Initiate and respond to telecom/intercom communications.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When initiating and responding to telecom/intercom communications, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Answered patient's signal.	( )	( )	( )	( )	( )
2. Identified patient, recorded name, room number, time and written message on form as appropriate.	( )	( )	( )	( )	( )
3. Relayed messages correctly within two minutes.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Receive and send articles by dumb waiter* or pneumatic tubes

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PERFORMANCE OBJECTIVE

Provided with the necessary equipment and information and confronted with the need to send six articles to the laboratory, send/remove articles by/from dumb waiter* or pneumatic tube. No article will be lost or spilled. (4)

PERFORMANCE GUIDE

1. Obtain the dumb waiter and place item(s) in it. Note: Items must be appropriately sealed and labeled. Newer hospital construction has replaced the dumb waiter with an assortment of pneumatic tubes and/or computerized devices. Central supply, laboratory, laundry, and dietary departments are frequently serviced with these devices.

   South Carolina version: Obtain pneumatic tube carrier and place item(s) in it. Items must be appropriately sealed and labeled.

2. Signal the unit for which item is intended making certain that unit responds.
3. Replenish your supply of carriers.
4. Answer the dumb waiter* ...{pneumatic tube system}... signal and open its door when it arrives.
5. Remove article(s) sent, and distribute to correct location.

LEARNING ACTIVITIES

1. Visit a unit and observe a pneumatic tube system in operation.
2. Practice opening and closing carrier.
3. Practice labeling and placing items in carrier.
4. Discuss the route of the carriers to appropriate destinations.
5. View "Pneumatic Tube System" training film.
6. Review information sheet titled "Pneumatic Tube System: Things to Remember."
7. Perform the sending and removal of articles by/from the pneumatic tube to the satisfaction of the instructor.

RESOURCES

film: "Pneumatic Tube System" (1975)
(MccPowers TransLogic 200/300 Training Film)
TransLogic Company, Denver Colorado

* {South Carolina writing team suggests omitting the words "dumb waiter."}

TOOLS AND EQUIPMENT

pneumatic tube system
articles
film projector

EVALUATION

Using provided materials, the student will send/remove six articles by/from dumb waiter* or pneumatic tube. The performance must earn a "fully accomplished" rating by the instructor.

V-TECS 75
L.A. #6

PNEUMATIC TUBE SYSTEM

Things to Remember

1. Never have more than three carriers at your station. If this should happen, push button at top, and return button at bottom. The system will automatically return carrier to the appropriate station.
2. May send up to three pounds when needed.
3. No fluids to be sent at this time.
4. Never send the second carrier until the first carrier has reached its destination.
5. When carrier returns, remove carrier immediately.
6. Stand out of way when carrier returns; for you could injure yourself.

V-TECS 75
L.A. #7

STUDENT________________________

DATE__________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Receive and send articles by dumb waiter or pneumatic tube.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When receiving and sending articles by dumb waiter or pneumatic tubes, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Sealed and labeled articles for sending.	( )	( )	( )	( )	( )
2. Signaled other unit and determined that signal was received.	( )	( )	( )	( )	( )
3. Removed articles sent and distributed to correct location.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Assemble/disassemble addressograph plate

PERFORMANCE OBJECTIVE

Given six addressograph bars ...(plates)..., blank labels, room-numbered plates and imprinter: assemble and disassemble addressograph plates. Assembled plate must print readably. Upon disassembly, the bar must be disposed of according to local policy. (4)

PERFORMANCE GUIDE

To Assemble:

1. Accept bar and face sheet from admitting office, verify data with the patient.
2. Select properly room-numbered plate.
3. Insert bar into plate.
4. Place plate in imprinter and prepare (color code) plate label.
5. Proofread the printed label verifying accuracy with admission face sheet. Note: If any error exists, a new bar must be obtained from admitting office.
6. Insert label into plate. Newer addressograph plates resemble credit cards and do not utilize this procedure, but must be checked for accuracy by the ward clerk before utilization.
7. Place labeled plate in designated spot in rack.

To Disassemble:

1. Remove label and bar from plate.
2. Return plate to designated area.
3. Dispose of label and bar in the manner designated by local policy.

(South Carolina writing team suggests slight changes in wording of performance guide. Refer to the following revised performance guide.)

PERFORMANCE GUIDE

To Assemble:

1. Accept plate and face sheet from admitting office; verify data with the patient.
2. Select properly room-numbered plate holder.
3. Insert plate into plate holder.
4. Place plate holder with plate into addressograph imprinter and prepare forms and requisitions.
5. Proofread the printed material verifying accuracy with admission face sheet. If any error exists, a new plate must be obtained from admitting office.

6. Place labeled plate in designated spot in rack.

To Disassemble:

1. Remove plate from plate holder.
2. Return plate holder to designated rack.
3. Dispose of plate in the manner designated by health care facility policy.

LEARNING ACTIVITIES

Assembly:

1. Discuss purpose and exhibit the following items: plate, plate holder, addressograph imprinter, and rack for storing plate holders.
2. Describe the procedure for checking admitting face sheet for correct information.
3. Demonstrate proper assembly and imprinting procedure to students.
4. Drill and practice assembling addressograph materials and imprinting forms.
5. Demonstrate method for correcting errors.
6. Perform the assembly for evaluation by the instructor.

Disassembly:

1. Demonstrate removal of plate from plate holder.
2. Read policy concerning discarding plate.
3. Drill and practice the disassembly of addressograph plates.
4. Perform the disassembly for evaluation by the instructor.

TOOLS AND EQUUIPMENT

addressograph
plate
plate holder
forms
requisitions
storage rack

EVALUATION

Using provided materials and information the student will assemble and disassemble addressograph plate. The plate must print clearly and be easily readable. Upon disassembly, the plate must be disposed of in complete accordance with policy of the health care facility. Performance must ultimately result in a "fully accomplished" rating by the instructor.

V-TECS 36
L.A. #6

STUDENT ______________________________

DATE ______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Assemble/disassemble addressograph plate.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When assembling/disassembling addressograph plate, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Assembled an addressograph plate.	( )	( )	( )	( )	( )
2. Disassembled an addressograph plate.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Initiate graphic sheet

PERFORMANCE OBJECTIVE

Given the required information, supplies, and a new graphic sheet: initiate the graphic sheet. Graphic sheet must satisfy legal charting requirements, and appearance must be neat and legible, correct ink color used, and the sheet must be photocopyable. (4)

PERFORMANCE GUIDE

1. Select and imprint graphic sheet with correct patient's addressograph plate.
2. Place dates in appropriate columns.
3. Place numbers of days in hospital in appropriate column.
4. Compute post-op days and record in appropriate column.
5. Determine that all recorded information is in correct location.
6. See that any corrections are legally performed or recopy entire sheet. Note: No erasures or ink eradicators are allowed.

LEARNING ACTIVITIES

1. Demonstrate the imprinting of addressograph material onto graphic sheet.
2. View overhead transparencies to discuss each section of graphic sheet while "Graphic/Intake - Output Record" procedures are being explained (information sheet attached).
3. Practice initiating graphic sheet, using instructor's checklist as guide for appropriateness.
4. Discuss ramifications if legal charting requirements are not rejected.
5. Perform the items listed on the instructor's checklist until receiving a "fully accomplished" rating.

TOOLS AND EQUIPMENT

red and black pens
overhead projector & transparencies

EVALUATION

Using materials provided, the student will initiate graphic sheet according to the activities listed in the instructor's checklist. A rating of "fully accomplished" must be achieved.

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GRAPHIC/INTAKE-OUTPUT RECORD

DEFINITION AND PURPOSE

The graphic chart is a flow sheet which gives concise report of temperature, pulse, respiration, blood pressure, weight, elimination and dietary intake. The intake and output section provides a summary of fluid intake and output.

POLICY

Graphic Section

1. Use black or blue ink for recording on the graphic sheet with the following exceptions:
   Use red ink to record:
   1. Pulse
   2. Stools
   3. Asterisks to indicate further information charted on Interdisciplinary Progress Notes
   4. Day post-operative and post-partum
   5. Errors

2. Correct errors by circling the errors and initialing. Use RED INK. Be sure that this does not interfere with correct charting.

3. TPRs recorded more often than every four hours are charted on Frequent Observation Record.

4. Write in temperature above 106° and below 95° and pulse above 150 and below 40.

I&O Section

1. A record of I&O is kept when deemed necessary upon nursing assessment and/or when ordered by a physician.

2. Enter totals at 6 a.m., 2 p.m. and 10 p.m.

3. Enter 24 hour total at 10 p.m.

RESPONSIBLE PERSONS

RN, LPN, NT, Ward Clerk (graphic chart)

GENERAL INSTRUCTION

1. Record from bedside Intake and Output Worksheet which is kept in the patient's room.

PROCEDURE

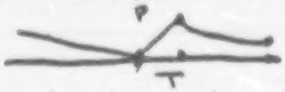
Graphic Chart:

1. Complete each section of the graphic chart as indicated below.

Date Line:
Complete Date Line using month, day and year on admission date; month and day thereafter.

Hospital Day/PO-PP Line:
a. Complete Hospital Day part, entering admission (adm.) in AM column. Then number following blocks consecutively beginning with one (1).
b. Complete Post Operative or Post Partum (PO-PP) day in PM column by entering Surgery or Delivery on appropriate day. Number blocks thereafter consecutively beginning with one (1). USE RED INK.

Graph - TPRs:
a. Chart TPR every four hours as necessary under correct date and hour.
b. Record pulses using red ink.
c. If temperature and pulse fall on the same line chart as follows:



d. Write in respirations using black ink.

Blood Pressure:
Record systolic blood pressure on top line; record diastolic blood pressure on bottom line. If BP is taken more often than q 4 hrs. use red asterisk in BP space to indicate that more BP's are charted on Frequent Observations Record.

Weight, Urine, Stools:
a. Chart admission and daily weight in "weight column".

b. Question the patient once daily at 4 p.m. regarding bowel movements from 4 p.m. yesterday until 4 p.m. today. Record reported bowel movements on the date it occurred.
c. Use the following symbols to record stool:
O-no stool $\overline{T}$-number of stools E-Enema
d. Use the following symbols to record urinary output:
O-has not voided $\overline{T}$-has voided c-Catheterized or catheter in place

Diet:
a. Use the following abbreviations for diets:

Regular	R
Soft	S
Surgical Liquids	SL
Full Liquids	FL
Bland	B
Low Residue	LR
Diabetic	D
Special	Sp
Nothing by mouth	NPO
Held Diet (not served, meal omitted)	O

b. Record abbreviations for type of diet for each meal.
c. Record amount patient ate beside diet using the following legend:
All
¼
½
3/4
None

d. Record intake on Intake and Output Section when the patient is on full liquid or surgical liquid diet.

Other Dietary Intake:

a. Intake instead of diet
   (1) Write (tube feeding, milk, formula, etc.) on first diet line.
   (2) Enter amount and frequency of feeding and times of feeding on second line.
   (3) Cross through hour after feeding is taken.

b. Nourishments in addition to diet
   (1) Record on line label "Other Dietary Intake."
   (2) Enter kind (eg. between meal or HS feedings) amount, and frequency of feeding.

(Use a red asterisk to indicate that a notation has been made in Interdisciplinary Progress Notes).

Intake and Output Section:

1. Chart all fluid intake including:
   a. Mouth - all fluid taken by mouth
   b. Parenteral - intravenous, clysis, blood
   c. Blank - label line tube feeding, rectal instillations, gastrostomy feedings, etc.

2. Chart all fluid output including:
   a. Urine - all urine voided and obtained by catheter.
   b. Blanks - label line tube drainage, emesis, liquid stool, hemorrhage, etc.

VARIATIONS

Newborn Nursery Graphic/Intake-Output Record

1. Graphic Section
   Weight: Chart admission weight in first space and daily weight in "weight" column under appropriate date.

2. Intake-Output Section
   Intake: Chart amount of formula the baby takes at each feeding by appropriate time in the amount column and the type of formula and ratio in the formula column, (ie, SIM 1:1)

   Output: a. Urine - chart frequency of voidings, ie, $\dot{T}$, $\dot{T}\dot{T}$, etc.
   b. Stools - chart frequency of stools and type of stool. (ie, $\dot{T}$, MEC (Meconium), etc.)

Use the following abbreviations for formula:

Water	D5W
Similac	SIM
Enfamil	EMF
Nutramigen	NUTRA
Isomil	ISO
Prosobee	PRO
Similac with Iron	SIMI
Enfamil with Iron	EMFI

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GRAPHIC/INTAKE - OUTPUT RECORD

DATE							
HOSP DAY/PO-PP							

HOUR	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4

CHART PULSE IN RED	CHART TEMPERATURE IN BLUE
140	105
130	104
120	103
110	102
100	101
90	100
80	99 Normal
70	98
60	97
50	96

RESPIRATIONS	
WEIGHT	

DATE			INTAKE					OUTPUT		
TIME	MOUTH	PARENTERAL			TOTAL	URINE				TOTA
10 – 6										
6 – 2										
2–10										
24 HR. TOTAL										

			INTAKE					OUTPUT		
TIME	MOUTH	PARENTERAL			TOTAL	URINE				TOTA
10 – 6										
6 – 2										
2–10										
24 HR. TOTAL										

			INTAKE					OUTPUT		
TIME	MOUTH	PARENTERAL			TOTAL	URINE				TOTA
10 – 6										
6 – 2										
2–10										
24 HR										

V-TECS 40
L.A. #5

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STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Initiate graphic sheet.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When initiating a graphic sheet, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Selected and imprinted graphic sheet with correct patient's addressograph plate.	( )	( )	( )	( )	( )
2. Placed dates in appropriate columns.	( )	( )	( )	( )	( )
3. Placed number of days in hospital in appropriate column.	( )	( )	( )	( )	( )
4. Computed post-op days and recorded in appropriate column.	( )	( )	( )	( )	( )
5. Determined that all recorded information was in correct location.	( )	( )	( )	( )	( )
6. Made sure corrections were legally performed.	( )	( )	( )	( )	( )
7. Made sure that only red or black ink had been used appropriately.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECORD KEEPING ACTIVITIES

TASK: Graph temperature, pulse, respiration

PERFORMANCE OBJECTIVE

Provided TPR worksheet and graphic TPR sheets for twelve ...{sixteen}... patients, graph the TPRs. Temperature must be charted to within two-tenths of a degree of that recorded on the worksheet; pulse and respiration must be within five digits of that recorded on the worksheet. (4)

PERFORMANCE GUIDE

1. Secure TPR worksheet.
2. Select color code ...{appropriate color of ink}... for charting based upon time of TPR and hospital policy.
3. Locate patient's chart and graphic sheet.
4. Locate time column for recording.

(South Carolina writing team suggests that items 1-4 follow this order: 1, 4, 2, 3.)

5. Extract patient's temperatuure informaton from worksheet.
6. Recognize unusual deviations from preceding data and report to team leader or charge nurse before charting.
7. Place enlarged dot on graphic sheet under time and temperature as recorded on the worksheet.
8. Connect last recorded temperature with a straight line. Note: Use of a ruler or other guide is recommended to obtain a neater, more legible graph.
9. Indicate method of taking temperature if other than oral by placing appropriate letter in parenthesis above dot.
10. Repeat procedure for pulse and respiration.
11. Indicate on worksheet that you have charted this TPR by drawing a line through information on worksheet and initialing same.
12. Replace chart in rack.

LEARNING ACTIVITIES

1. Visit units to observe where TPR worksheet, patient's chart and graphic sheet are kept and how they are used.
2. Introduce information sheet titled "Patient History and Nursing Observation" (attached). Explain that this sheet is where initial TPRs are recorded to be transcribed later to graphic sheet.
3. Review Graphic/Intake - Output Record regarding charting of these areas. (Refer to preceding lesson.)
4. Demonstrate, using overhead transparencies, the actual charting of TPRs with any deviations or corrections noted.

5. Practice in class charting TPRs for sixteen patients. (Use attached information sheet titled "Twenty-Four Hour Record of Patient's Temperature.")
6. Use the instructor's checklist to demonstrate mastery of task.

TOOLS AND EQUIPMENT

red and black pens
overhead projector and transparencies
appropriate forms

EVALUATION

Using provided materials, the student will record TPRs on graphic sheet for sixteen patients. A rating of "fully accomplished" must be achieved on the instructor's checklist.

V - TECS 77
L.A. #2

PATIENT HISTORY AND NURSING OBSERVATION

(ADDRESSOGRAPH)

SECTION I

ADMISSION DATA

DATE HOUR
MODE OF ARRIVAL
ACCOMPANIED BY
TPR BP
HT WT
VALUABLES: RINGS
WATCH
MONEY
OTHERS:

ROOM ORIENTATION

INTRODUCED TO HOSPITAL HANDBOOK
CALL LIGHT AND BEDSIDE CONTROLS
BATHROOM AND SHOWER
VISITING RULES
SMOKING POLICY
SIDERAIL POLICY
IDENTIFICATION BAND ON
MEAL TIMES

PROSTHESIS: DENTURES
CAPS
CONTACT LENS:
UPPER LIMB
LOWER LIMB
GLASSES
ARTIFICIAL EYE: R
L
HAIRPIECE

DISPOSITION OF VALUABLES
HOW CAN FAMILY BE REACHED DURING HOSPITALIZATION?
SIGNATURE OF RN OR LPN COMPLETING SECTION I:

SECTION II

PRESENT ILLNESS

REASON FOR HOSPITALIZATION
ONSET/DURATION

ILLNESSES

PREVIOUS ILLNESSES/HOSPITALIZATION	DATES	SURGERIES	DATES

CHRONIC DISEASES (DIABETES, ASTHMA, HYPERTENSION, EMPHYSEMA, HEART DISEASE, GLAUCOMA, SEIZURES)

MEDICATION HISTORY

MEDICATION	DOSAGE	TIMES USUALLY TAKEN-CIRCLE THOSE TAKEN TODAY

MEDICATION DISPOSITION:

ALLERGIES SENSITIVITIES

ALLERGIES AND SENSITIVITIES: (FOOD, DRUG, X-RAY CONTRAST MEDIUM, ETC.)
(RECORD IN RED)
DESCRIBE REACTION

SIGNATURE OF LPN OR RN COMPLETING SECTION II:

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SECTION III

NURSING OBSERVATIONS

SKIN: (REDNESS, BRUISES, SWELLING, BROKEN AREAS, RASH, DRY, COLOR, TEMPERATURE OF SKIN)

NEURO: (ALERT, ORIENTED, SPEECH, DIZZINESS)

RESPIRATORY: (SHORTNESS OF BREATH, COUGH, SPUTUM, HISTORY OF SMOKING)

CARDIOVASCULAR: (CHEST PAIN, HEART RHYTHM - REGULAR, IRREGULAR, VARICOSE VEINS, PULSES)

GI: (DISTENDED ABDOMEN, ELIMINATION PATTERNS, APPETITE, NAUSEA, VOMITING, DIFFICULTY SWALLOWING, USUAL DIET)

GU: (FREQUENCY, PAIN, COLOR OF URINE, DISCHARGE)

GYN: (MENSTRUAL HISTORY, VAGINAL DISCHARGE OR BLEEDING)

EENT AND MOUTH: (VISUAL OR HEARING PROBLEMS, BLEEDING GUMS, HOARSENESS)

EXTREMITIES: (EDEMA, MOVES ALL EXTREMITIES, COLOR OF NAIL BEDS)

OTHER ASSESSMENTS: (PSYCHOLOGICAL AND SOCIOLOGICAL)

PATIENT PROBLEMS: (INCLUDE ANTICIPATED PROBLEMS AND LEARNING NEEDS)

1.
2.
3.
4.
5.

SIGNATURE OF RN COMPLETING SECTION III: ____________________

TWENTY-FOUR HOUR RECORD O

(Weight and

ROOM	NAME	WEIGHT	B/P	8 AM	12 N
			110/60	99^6-96-20	
				98-64-20	
			150/94	100-84-18	
				96^8-98-20	
				101-86-20	
			120/80	97^6-82-18	
				96^6-70-20	
				97-64-18	
				100-76-20	
				99^8-68-20	
				96^5-80-20	
				100-86-18	
			140/90	97^6-82-20	
				101-94-18	
				100-86-20	
				101-96-18	

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V - TECS 77
L.A. #5

FOUR HOUR RECORD OF PATIENTS TEMPERATURES

(Weight and Elimination)

8 AM	12 NOON	4 PM	U	S	8 PM	12 MN	4 AM
99^{6}-96-20		97-60-18	$\frac{\cdot}{1}$	0/0	98^{6}-72-20		
98.64.20		100.76.20	0/0	·/·	100-78-18		
100.84.18		99^{3}-80-18	$\frac{\cdot\cdot}{11}$	0/0	99^{6}-96-20		
96^{8}-98-20		97-82-20	0/0	·/·	97^{6}-82-20		
101-86-20		101-104-20	$\frac{\cdot\cdot}{11}$	0/0	96^{6}-50-20		
97^{6}-82-18		97^{6}-84-20	0/0	·/·	98^{6}-68-18		
96^{6}-70-20		99^{6}-66.18	0/0	0/0	99^{6}-60-18		
99-64-18		100^{3}-78-20	·/1	0/0	99^{4}-58-18		
100.76.20		99-76-18	0/0	$\frac{\cdot\cdot}{11}$	101-96-20		
99^{8}-68-20		100^{1}-84-20	0/0	$\frac{\cdot}{1}$	98^{2}-68-18		
96^{5}-80-20		98^{8}-72-20	·/1	0/0	96^{6}-72-18		
100-86-18		97^{5}-56-20	·/1	0/0	100-96-18		
97^{6}-82-20		101^{2}-96-18	0/0	$\frac{\cdot\cdot}{11}$	102-100-20		
101-94-18		102-100-18	0/0	·/1	100-96-20		
100.86-20		99^{6}-94-18			96^{6}-72-18		
101-96-18		100-89-20			99^{2}-86-20		

V-TECS 77
L.A. #6

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Graph temperature, pulse, respiration.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When graphing temperature, pulse and respiration, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Charted temperature within two-tenths of a degree of that recorded on the worksheet.	( )	( )	( )	( )	( )
2. Charted pulse and respiration within five digits of that recorded on the worksheet.	( )	( )	( )	( )	( )
3. Used correct color pens for recording.	( )	( )	( )	( )	( )
4. Corrected any errors and showed deviations according to hospital policy.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

V-TECS 76

DUTY: PERFORMING RECORD KEEPING ACTIVITIES

TASK: Chart data from information supplied such as weight, B.P., diet, B.M., I. & O.

(South Carolina writing team suggests omission of "diet" and "I. & O.")

PERFORMANCE OBJECTIVE

Given the charts of forty patients and supplied with information on worksheets: chart the B.P., diet, weight, I. & O., and B.M. of ten ...{sixteen}... patients. Charting must satisfy legal requirements and standards as identified in posted policies and chart form must be legible, neat, and photocopyable. (4)

PERFORMANCE GUIDE

1. Identify data to be charted; verify source of information. Note: (1) Entries in medical records may be made only by persons given this right under hospital policy: A method must be established to identify the authors of entries. J.C.A.H., "Standard III." (2) Nurses' notes and entries by allied health personnel should contain only pertinent, meaningful observations and information. J.C.A.H., "Standard II."
2. Select ink color, this hospital's policy.
3. Locate patient's chart.
4. Locate place on appropriate chart form for this entry.
5. Recognize unusual deviations from preceding data and report to charge nurse or team leader before charting. Note: Intake and output data collecting forms will need to be totaled before entering the information on the I. & O. summary sheet. Ounces may need to be converted to cubic centimeters or milliliters.

(South Carolina writing team suggests that the note in item #5 be omitted and classified as a responsibility of the nursing staff.)

6. Copy data correctly and legibly. Note: Must be photocopyable.
7. Place a line through information on worksheet and your initials to indicate that you have charted this information.
8. Replace chart.

LEARNING ACTIVITIES

1. Visit a unit to observe where weight, B.P., B.M. worksheet, patient's chart and graphic sheet within chart are kept and how these sheets are used.
2. Review Lesson 12, V-TES OBJ. 77 (i.e., "Patient History and Nursing Observation" sheet). Note that this sheet is where initial weight, B.P., and B.M. are recorded to be later transcribed to graphic sheet.

3. Review Lesson 11, V-TECS, OBJ. 40 (i.e., "Graphic/Intake Output" record) regarding charting of these areas.
4. Demonstrate, using the overhead projector, the actual charting of weight, B.P., and B.M.
5. Drill and practice in class charting weight, B.P. and B.M. for 16 patients. Refer to information sheet titled "Twenty-Four Hour Record of Patient's Temperatures (Weight and Elimination)" (attached).
6. Demonstrate mastery of the task by performing the activities on the instructor's checklist and achieving a "fully accomplished" rating.

TOOLS AND EQUIPMENT

red and black pens
appropriate forms
overhead projector and transparencies

EVALUATION

Using accepted hospital policy, information and materials provided, the student will chart the weight, B.P., and B.M. for sixteen patients. All items on the instructor's checklist must receive a "fully accomplished" rating.

V - TECS 76
L.A. #5

TWENTY-FOUR HOUR RECORD OF PATIENTS TEMPERATURES

(Weight and Elimination)

ROOM	NAME	WEIGHT	B/P	8 AM	12 NOON	4 PM	U	S	8 PM	12 MN	4 AM
#3	Patient	192	154/90	99^{6}-68-20	98^{8}-70-18	97-80-20	0/1	1/0	98^{8}-92-22	99^{2}-86-20	98^{6}-62-20
				100^{1}-78-20	101-88-20	98^{6}-64-22	0/0	1/1	99^{4}-78-18	99^{8}-84-22	99^{2}-78-20
				98^{6}-84-20	97^{2}-76-18	100^{3}-76-18	1/1	0/0	99-86-20	98^{4}-90-18	99^{6}-82-22
				96^{4}-68-18	97^{8}-82-22	99-74-20	0/0	0/0	100-82-18	99^{4}-78-20	101-87-20
		196	180/100	100-82-20	99-64-18	98^{4}-68-18	1/1	1/0	97^{4}-78-20	99-94-20	99-78-20
				98^{4}-97-18	99^{4}-68-20	100-76-20	0/0	0/0	99-64-18	100-78-18	101-94-18
				99-70-20	97^{6}-58-20	100^{8}-86-18	1/1	1/1	99^{1}-72-20	98-64-20	99^{6}-74-20
		200	176/96	98^{3}-87-22	101-88-22	99^{9}-68-20	0/0	1/1	100^{2}-78-22	97^{9}-58-20	98^{8}-62-18
				102-100-22	101-94-20	99^{8}-68-20	1/1	1/1	101-98-18	100-84-20	98^{8}-72-20
		189	120/80	97-70-20	98^{8}-68-18	97^{4}-80-18	0/0	0/0	99^{2}-96-20	98-68-20	97^{6}-58-20
				99^{4}-80-18	100^{6}-99-20	101-98-20	1/1	1/1	102-100-20	100^{4}-86-20	97^{6}-84-20
				101-110-22	102-96-20	100^{4}-82-18	0/0	0/0	99^{6}-78-18	97^{8}-68-20	100-78-20
				98^{8}-72-22	99^{8}-78-20	97^{6}-58-20	1/1	1/1	96^{6}-68-20	100-86-20	101^{6}-86-20
				99-78-20	98-60-18	100-90-20	0/0	0/0	99^{6}-58-20	98^{8}-86-20	100-96-20
				98^{6}-68-22	97-90-22	100-86-22	1/1	1/0	102-110-18	99^{6}-76-20	97^{6}-80-22
				101-90-20	99^{8}-72-20	97-58-18	0/0	0/0	96-60-18	95^{8}-58-20	99^{6}-78-20
				100-98-20	100^{6}-92-18	99^{6}-78-20	1/1	1/1	99^{6}-72-20	100-80-20	99-76-20

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V-TECS 76
L.A. #6

STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:
Chart data from information supplied such as weight, B.P., diet, B.M., I. & O.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When performing record keeping activities, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Charted data on weight, B.P., and B.M. in correct area on graphic sheet.	( )	( )	( )	( )	( )
2. Used correct color pens for recording.	( )	( )	( )	( )	( )
3. Corrected any errors and showed deviations according to hospital policy.	( )	( )	( )	( )	( )
4. Wrote legibly, neatly, and sufficiently clear for photocopying.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Check new patient's allergy record, flag chart and Kardex (South Carolina writing team suggests this wording: Check new patient's Patient History and Nursing Observation profile sheet, flag chart and appropriate forms.)

PERFORMANCE OBJECTIVE

Given information concerning a new patient's allergies, the patient's Kardex cards and chart, an allergy flag, and appropriate forms, record the allergies in all designated locations. If no known allergies exist, state as such. All allergies existing must be recorded without error. (4)

PERFORMANCE GUIDE

1. Locate allergy record.
2. Notify charge nurse of data and copy onto appropriate forms in red ink as per hospital policy (Kardex cards, medicine sheet, nurses notes, signs).
3. Prepare allergy flag and place on front of chart so that it is clearly visible.
4. Prepare and apply an allergy bracelet if used in this hospital.
5. If no known allergies, record as "no known allergies."
6. Proofread all copied data.
7. Post special signs at bedside if required.

LEARNING ACTIVITIES

1. Distribute and discuss Patient History and Nursing Profile Sheet (attached). Point out where to look for allergies.
2. Distribute appropriate forms (Medication Administration Record, Physician's Orders) (attached) and show where to chart allergies in red on forms.
3. Demonstrate the correct procedure for flagging patient's chart (example attached).
4. Listen to classroom resource speaker (i.e., an allergist) address the topic of "Allergies - Dangers and Precautions."
5. Demonstrate procedure for checking allergy records and flagging charts. Instructor must rate demonstration as "fully accomplished."

RESOURCES

physician (allergist)

TOOLS AND EQUIPMENT

allergy tape
appropriate forms
red pen

EVALUATION

Using supplied information and materials, the student will record one patient's allergies on all required forms. All existing allergies must be recorded without error. Demonstration must earn a "fully accomplished" rating by instructor.

V - TECS 37
L.A. #1

PATIENT HISTORY AND NURSING OBSERVATION

(ADDRESSOGRAPH)

SECTION I

ADMISSION DATA

DATE ________ HOUR ________
MODE OF ARRIVAL ________
ACCOMPANIED BY ________
TPR ________ BP ________
HT ________ WT ________
VALUABLES: RINGS ________
WATCH ________
MONEY ________
OTHERS: ________

ROOM ORIENTATION

INTRODUCED TO HOSPITAL HANDBOOK ________
CALL LIGHT AND BEDSIDE CONTROLS ________
BATHROOM AND SHOWER ________
VISITING RULES ________
SMOKING POLICY ________
SIDERAIL POLICY ________
IDENTIFICATION BAND ON ________
MEAL TIMES ________

PROSTHESIS: DENTURES ________
CAPS ________
CONTACT LENS: ________
UPPER LIMB ________
LOWER LIMB ________
GLASSES ________
ARTIFICIAL EYE: R ________
L ________
HAIRPIECE ________

DISPOSITION OF VALUABLES ________
HOW CAN FAMILY BE REACHED DURING HOSPITALIZATION? ________
SIGNATURE OF RN OR LPN COMPLETING SECTION I: ________

SECTION II

PRESENT ILLNESS

REASON FOR HOSPITALIZATION ________
ONSET/DURATION ________

ILLNESSES

PREVIOUS ILLNESSES/HOSPITALIZATION	DATES	SURGERIES	DATES

CHRONIC DISEASES (DIABETES, ASTHMA, HYPERTENSION, EMPHYSEMA, HEART DISEASE, GLAUCOMA, SEIZURES)

MEDICATION HISTORY

MEDICATION	DOSAGE	TIMES USUALLY TAKEN-CIRCLE THOSE TAKEN TODAY

MEDICATION DISPOSITION: ________

ALLERGIES SENSITIVITIES

ALLERGIES AND SENSITIVITIES: (FOOD, DRUG, X-RAY CONTRAST MEDIUM, ETC.)
(RECORD IN RED)
DESCRIBE REACTION

SIGNATURE OF LPN OR RN COMPLETING SECTION II: ________

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V - TECS 37
L. A. #1

SECTION III
NURSING OBSERVATIONS

SKIN: (REDNESS, BRUISES, SWELLING, BROKEN AREAS, RASH, DRY, COLOR, TEMPERATURE OF SKIN)

NEURO: (ALERT, ORIENTED, SPEECH, DIZZINESS)

RESPIRATORY: (SHORTNESS OF BREATH, COUGH, SPUTUM, HISTORY OF SMOKING)

CARDIOVASCULAR: (CHEST PAIN, HEART RHYTHM - REGULAR, IRREGULAR, VARICOSE VEINS, PULSES)

GI: (DISTENDED ABDOMEN, ELIMINATION PATTERNS, APPETITE, NAUSEA, VOMITING, DIFFICULTY SWALLOWING, USUAL DIET)

GU: (FREQUENCY, PAIN, COLOR OF URINE, DISCHARGE)

GYN: (MENSTRUAL HISTORY, VAGINAL DISCHARGE OR BLEEDING)

EENT AND MOUTH: (VISUAL OR HEARING PROBLEMS, BLEEDING GUMS, HOARSENESS)

EXTREMITIES: (EDEMA, MOVES ALL EXTREMITIES, COLOR OF NAIL BEDS)

OTHER ASSESSMENTS: (PSYCHOLOGICAL AND SOCIOLOGICAL)

PATIENT PROBLEMS: (INCLUDE ANTICIPATED PROBLEMS AND LEARNING NEEDS)

1.
2.
3.
4.
5.

SIGNATURE OF RN COMPLETING SECTION III:

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V - TECS 3
L.A. #2

All Entries Must Be Printed

Medication Administration Record

Enter Here IN PENCIL Number of Forms in Use ☐

Name

Case No.

Room No.

Diagnosis ______________________

Surgery ______________________

Allergic Test (Record in Red) ______________________

DATES GIVEN

Form No. 3[illegible]

OR Date Initials	Exp. Date Time	Medication—Dosage—Rt. of Adm.	HR.													

SINGLE ORDERS – PRE-OPERATIVES

Enter here in pencil No. of Forms in use ☐

OR Date Initials	Medication — Dosage — Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial	OR Date Initials	Medication — Dosage — Frequency — Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial

(PRN ORDERS – SEE REVERSE SIDE)

Doctor ______________ **Intern** ______________ **Date/Time Admitted** ______________

Age ______ **Religion** ______________ **Date/Time Discharged** ______________

Name ______________

SIGNATURE	TITLE	SIGNATURE	TITL.

PRN Medications

Nurse giving a PRN medication enters, next to the medication, vertically, the date – time given and initials for each dose given.

Or Date Initials	Exp. Date Time	Medication — Dosage — Frequency — Rt. of Adm.	DOSES GIVEN																					

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V - TECS 37
L. A. #2

PHYSICIAN'S ORDERS

AUTOMATIC STOP ORDER: SCHEDULE OF STOP DATES REPRODUCED BELOW IS IN TERMS OF DAYS FOLLOWING DATE OF ORIGINAL ORDER. IF STOP DATE FALLS ON SUNDAY OR HOLIDAY ORDER EXTENDED ONE DAY. TIME 11:00 A.M.

THIS ORDER DOES NOT APPLY WHEN PHYSICIAN'S ORDER INDICATES EXACT NUMBER OF DOSES AND/OR DAYS TO BE ADMINISTERED.

ANTIBIOTICS. 7
SCHEDULE III MEDICATIONS 7
SCHEDULE II MEDICATIONS. . . . .

DO NOT WRITE IN THIS SECTION IF RED ↑

(✓) START → HERE | DATE | TIME A.M. P.M. | ALLERGIES: ✓

(1)

(ADDRESSOGRAPH)

M.D. DISPENSE AS WRITTEN
M.D. SUBSTITUTION PERMITTED

DO NOT WRITE IN THIS SECTION IF RED ↑

(✓) START → HERE | DATE | TIME A.M. P.M. | ALLERGIES: ✓

(2)

(ADDRESSOGRAPH)

M.D. DISPENSE AS WRITTEN
M.D. SUBSTITUTION PERMITTED

DO NOT WRITE IN THIS SECTION IF RED ↑

(✓) START → HERE | DATE | TIME A.M. P.M. | ALLERGIES: ✓

(3)

(ADDRESSOGRAPH)

M.D. DISPENSE AS WRITTEN
M.D. SUBSTITUTION PERMITTED

V - TECS 37
L. A. #3

For Front of Chart

ALLERGIC: Penicillin

V-TECS 37
L.A. #5

STUDENT____________________________

DATE_______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:
Check new patient's allergy record, (Patient History), flag chart and Kardex (appropriate forms).
Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When checking new patient's allergy record, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Recorded patient's allergies on all required forms.	( )	( )	( )	( )	( )
2. Prepared an allergy bracelet and allergy flag and obtained special bedside sign.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Prepare medicine sheets ...{Medication Administration Record}...

PERFORMANCE OBJECTIVE

Given all required information and supplies, prepare the medicine sheet notebook ...{Medication Administration Record}... for a given day. New forms must be accurate, complete, and legible. (4)

PERFORMANCE GUIDE

1. Identify patient's medicine sheet to be recopied. Note: Used with Brewer System, and occasionally with other drug administration systems.
2. Select medicine sheet forms to be prepared.
3. Imprint form with correct patient's addressograph plate.
4. Enter dates in spaces provided.
5. Copy date ordered, name of drug, amount, number of times to be given daily, and mode of administration for each drug currently to be administered to this patient.
6. Check medicine sheet with Kardex (medication section).
7. Proofread for accuracy.
8. Report any discrepaancies to charge nurse.
9. Give **both** medicine sheets to the medicine nurse for checking before utilization.
10. Prepare medicine sheet for each new admission and give to medicine nurse for checking.

The South Carolina writing team suggests a slight revision in the wording of the Performance Guide. Please note the following eleven items.

SOUTH CAROLINA PERFORMANCE GUIDE

1. Select a Medication Administration Record Form (MAR) to be prepared.
2. Imprint form with correct patient's addressograph plate.
3. Complete top and bottom portions of form.
4. Enter dates in spaces provided.
5. (a) Copy from physician's orders the date ordered, date of expiration, name of drug, amount, number of times to be given daily, and mode of administration for each drug currently to be administered to patient.
   (b) Prepare single order and stat order cards and paper clip to MAR.
6. Proofread for accuracy.
7. Use proper procedure for correcting errors.
8. Give MAR to nurse in charge of patient for checking before utilization.
9. Prepare MAR for each new admission and give to patient's charge nurse for checking.

10. Update MAR daily as Medication orders are given by physician.
11. Place MAR in Kardex on medicine cart.

LEARNING ACTIVITIES

1. Distribute and discuss the attached Medication Administration Record (MAR).
2. As a homework assignment, study and memorize, as appropriate, the content of the information sheet titled "Discussion of Medication Administration Record."
3. Demonstrate, by using a transparency of the Medication Administration Record, the correct method for completing the top and bottom portions of the form.
4. Demonstrate, by using a transparency of the MAR, the procedure for completing the date line.
5. Visit a unit and observe a ward clerk transcribing each medication from a physician's orders.
6. Simulate in class the transcription of medication from physician's orders, including single and stat orders. The instructor will provide physician's order for use by the entire class. (Refer to attached information sheet, if necessary.)
7. Memorize the information sheet titled "Continued Medication Hours" (attached).
8. Learn about importance of knowing hours by listening to guest speakers who are RN or MD.
9. Review the different medications and discuss where/why they are placed on MAR.
10. Visit a unit and see where the Kardex is kept and review several MARs.
11. Take a teacher-prepared test based on the "Discussion of Medication Administration Record."
12. Prepare a MAR which will be evaluated by the instructor.

RESOURCES

experienced ward clerk
registered nurse or physician

TOOLS AND EQUIPMENT

addressograph
pens, pencils
transparencies
overhead projector and transparencies

EVALUATION

Using materials provided, the student will prepare a Medication Administration Record (or medicine sheet). The content must be 100% accurate; it must also receive a "fully accomplished" rating by the instructor in regard to completeness and legibility.

V - TECS 50
L.A. #1

All Entries Must Be Printed

Medication Administration Record

Enter Here IN PENCIL Number of Forms in Use ☐

Name

Case No.

Room No.

Diagnosis ____________________

Surgery ____________________

Allergic Test (Record in Red) ____________________

DATES GIVEN

Form No. 3

OR Date Initials	Exp. Date Time	Medication—Dosage—Rt. of Adm.	HR.														

SINGLE ORDERS – PRE-OPERATIVES

Enter here in pencil No. of Forms in use ☐

OR Date Initials	Medication — Dosage — Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial	OR Date Initials	Medication — Dosage — Frequency — Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial

(PRN ORDERS – SEE REVERSE SIDE)

Doctor ____________________ Intern ____________________ Date/Time Admitted ____________________

Age ________ Religion ____________________ Date/Time Discharged ____________________

Name ____________________

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122

V - TECS 50
L.A. #2

MEDICATION ADMINISTRATION RECORD (MAR)

DEFINITION AND PURPOSE

The Medication Administration Record (MAR) provides a legal record of medication administration.

POLICY

1. Initiate a Medication Administration Record (MAR) for each patient on admission.
    a. Enter continued, single and pre-operative orders on the front of the form in appropriate sections.
    b. Enter PRN orders on the back of the form with exception of sleep medications and laxative PRNs which are recorded on the front of the form.
2. Use black ink for hours between 7:00 a.m. and 6:59 p.m., use red ink for hours between 7:00 p.m. and 6:59 a.m. Record 7 a.m. in black ink, 7 p.m. in red ink.
3. Use the following hours for administering medications unless the doctor orders specific hours.

Daily . . . . 9 a.m. (usually)

q.i.d. . . . . 9 a.m. - 1 p.m. - 5 p.m. - 9 p.m.

t.i.d. . . . . 9 a.m. - 1 p.m. - 5 p.m.

b.i.d. . . . . 9 a.m. - 9 p.m. or 9 a.m. - 5 p.m.

q^{4}h . . . . 1 a.m. - 5 a.m. - 9 a.m. - 1 p.m. - 5 p.m. - 9 p.m.

q^{6}h . . . . 4 a.m. - 10 a.m. - 4 p.m. - 10 p.m.

q^{8}h . . . . . . 5 a.m. - 1 p.m. - 9 p.m. or 1 a.m. - 9 a.m. - 5 p.m.

q^{12}h . . . . 9 a.m. - 9 p.m.

The following medication hours apply to Pediatrics:

b.i.d. . . . . 9 a.m. - 8 p.m.

q.i.d. . . . . 9 a.m. - 1 p.m. - 5 p.m. - 8 p.m.

q^{6}h . . . . 4 a.m. - 10 a.m. - 4 p.m. - 10 p.m. or
6 a.m. - 12 N - 6 p.m. - 12 MN

The following medication hours apply to Orthopedics:

Daily . . . . 8 a.m.

b.i.d. and $q^{12}h$ . . . 8 a.m. - 9 p.m.

t.i.d. . . . . 8 a.m. - 12 N - 5 p.m.

q.i.d. . . . . 8 a.m. - 12 N - 5 p.m. - 9 p.m.

q^4h . . . . 4 a.m. - 8 a.m. - 12 N - 4 p.m. - 8 p.m. - 12 MN

The following medication hours apply to Psychiatric:

Daily . . . . 8 a.m.

b.i.d. . . . . 8 a.m. - 4 p.m. or 8 a.m. - 8 p.m.

t.i.d. . . . . 8 a.m. - 12 N - 4 p.m.

q.i.d. . . . . 8 a.m. - 12 N - 4 p.m. - 8 p.m.

q^4h . . . . 4 a.m. - 8 a.m. 12 N - 4 p.m. - 8 p.m. - 12 MN

q^6h . . . . 6 a.m. - 12 N - 6 p.m. - 12 MN

q^8h . . . . 8 a.m. - 4 p.m. - 12 MN

$q^{12}h$ . . . . 8 a.m. - 8 p.m.

4. Account for all squares by initialing, "x"ing out, or entering red asterisks (*) or circling surgery or X-ray in red.
5. Enter expiration dates in pencil. The expiration date is three days (72 hours) or seven days (168 hours) on all controlled drugs depending on drug classification.
6. Validate all initials on MAR by signing full name and title on back of form.
7. Record allergies in red and surgery and diagnosis in black ink at top right section of the MAR.
8. Do not discontinue medication when the patient goes to surgery.
9. Discontinue postoperatively those medications not reordered.
10. Complete bottom section of MAR (doctor, age, name and date and time of admission and discharge).

RESPONSIBLE PERSONS

RN, LPN
Unit Secretary - Transcribe order, complete date line, fill in top and bottom headings on MAR.

GENERAL INSTRUCTIONS

1. Do not repeat charting in Interdisciplinary Progress Notes. Document results of PRN medication in IDP notes. It is not necessary to include dosage or route of administration.
2. Do not record treatments on Medication Administration Record.
3. Place a large number in pencil in the box on the top right of the MAR to indicate how many forms are in current use.
4. When a patient goes to surgery and medications are continued postoperatively write in red above transcription of medication orders POST-OP and the surgery date. If a dose or doses were not given while the patient was in surgery, do the following when patient returns to unit from recovery room; write "surg" in red and circle it in red in the time slots missed. Under the last entry in the single orders section write POST-UP and date in red when a patient goes to surgery. If medications are not renewed postoperatively, discontinue medications in usual manner.
5. Use medicine card to flag Kardex when pre-op, single order drugs are to be given. Write in center of card "S.O." or "Pre-Op" and along edges write dates and times medication is due.
6. When any part of the medication order is changed (i.e.: time, dose, route, etc.) discontinue the present order and rewrite the entire order in appropriate place. Do not cross through the present order and write in the new order (i.e.: IM, IV)
7. If patient goes to surgery multiple times during one hospitalization, write in red ink "and," the type of surgery and the date after the first post-op date on the MAR.
8. If an antibiotic is ordered qid check with the physician to see if he wants the medication given around the clock.

PROCEDURE

1. Chart Continued Medications (**medications given on regular basis**) as follows:
   a. Enter on front top section of MAR.
   b. Enter expiration date when applicable in pencil.
   c. Transcribe by entering order date, initials of person transcribing order, and medication, dosage, frequency, route of administration in column specified.
   d. List hours medication is to be given vertically under HR column. Use a new line for each hour, beginning with the first hour listed under policy.
   e. Draw a heavy line across the page after the last hour is entered. Leave one vacant space and draw another line.
   f. Complete "Dates Given" line horizontally beginning with first date a continued medication order is written.
   g. "X" out all squares preceding the first dose of medication administred.
   h. "X" out squares under the dates medication is **NOT TO BE GIVEN** when a medication is to be given every other day; given one day, left off two, etc.
   i. Number the appropriate squares when medication is to be given for a specific number of doses. Place a penciled "X" in the two

columns following the last dose due. Bracket and write in pencil "STOP" with time and date. Nurse giving the last dose "STOPS" the medication in the usual manner.

j. Initial the square corresponding to the **Correct Date and Correct Time** after the medication is given.

k. Enter the actual time the medication is given and initials of person administering in the appropriate square(s) when a medication is given at a time different from ordered time.

l. Document omitted drugs as follows:

   1. if patient is in X-ray and misses tid, quid, q^4h, or q^6h medications enter "X-ray" and circle it in red in the block where your initials would have gone.
   2. if a patient is in surgery (see General Instructions 4).
   3. if a patient misses a medication for any other reason place a red asterisk (*) in the appropriate square(s). A corresponding red asterisk (*) is made on the IDP notes along with reason medication was omitted.

m. Divide block into half diagonally if the medication is being administered by injection. Place code for injection site in top half of block and initials in bottom half of block.

n. Discontinue medications by drawing one red line through the complete medication order and down the hour(s) in the Hours Column. "X" out the remaining square(s) for that day, and the next full days squares. Bracket the "X"ed out square(s) and print the word STOP, your initials and the date after the bracket.

o. Enter PRN sedatives and PRN in red ink. When laxative or sedative PRNs are given enter the time given and initials in appropriate space; "X" out the square on the date a dose is omitted.

2. Chart **Single Orders and Pre-Operative Medications** as follows:
   a. Transcribe by entering order date, initials of person transcribing order.
   b. Enter medication order as written.
   c. Enter date and time medication was given or is to be given under TO BE GIVEN column.
   d. Initial NURSE column **after** giving medication.
   e. Use medication card to flag Kardex when single order and pre-op medications are due.

3. Chart **PRN Medications** as follows:
   a. Enter on back of form in PRN Medications section.
   b. Transcribe order by entering order date, expiration date (in pencil), initials, and order including medication, dosage, frequency, and route of administration.
   c. Write PRN and reason for giving in red.
   d. Chart that medication was given by entering vertically, the date, the time, initials and injection site if applicable beside the appropriate medication when each dose is given.
   e. Transcribe each PRN order on a new set of three lines.
   f. Discontinue PRN medications by drawing a single red line through the entire order, "X"ing out two (2) columns, bracket in the time, write STOP, the date, and your initials. Refer to MAR accompanying this procedure for examples.

g. Document dose given in square when a range of medication is ordered along with time of administration. Divide dose and time with a line.

V - TECS.5C
L. A. #6

All Entries Must Be Printed

Medication Administration Record

Name

Case No. Stamp c̄ Name Plate

Room No.

Diagnosis D.U.B

Enter Here IN PENCIL Number of Forms in Use 1

Surgery 11-1-82 Vaginal Hysterectomy and

Allergic Test (Record in Red) A.S.A 11-2-82

(Used Ink)

DATES GIVEN

Form No. 309

OR Date Initials	Exp. Date Time	Medication—Dosage—Rt. of Adm.	HR.	10/31	11/1	11/2	11/3	11/4	11/5	11/6	11/7	11/8	11/9	11/10	11/11	11/12
10/31		Keflex - 500mgm P.O.	9													
		Q.I.D	1													
			5	J.C												
			9	J.C												
		Post-OP - Date														
11/1		KEFLIN Gm ÷ I.V	4			[illegible]	[illegible]									
		piggyback q 6 hr's	10			[illegible]	[illegible]									
		X 8 Dose's	4		[illegible]	[illegible]										
			10		[illegible]	[illegible]										
11/2	9	Dalmane. 30 mg. P.O	9													
		P.R.N.														
11/2		Sliding Scale A.C and	7:30				Sp									
		Give Regular Insulin SQ	Dose				0									
		according to Blood Sugar level	11:30			Jc	SP									
		AS Follow's:	Dose			#2/[illegible]	#5/[illegible]									
		400-500 mg % - 20 Units SQ	4:30			Jt	Jt									
		300-400 mg % - 15 Units SQ	Dose			#1/[illegible]	#4/[illegible]									
		200-300 mg % - 10 Units SQ	9													
		100-200 mg % No Insulin	Dose													

Stop Surg - Date c̄ initial / title

D/C p̄ 10D. m Dose 11-3-82

(Use Pencil)

(Use Pencil)

SINGLE ORDERS – PRE-OPERATIVES

Enter here in pencil No. of Forms in use I

OR Date Initials	Medication — Dosage — Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial	OR Date Initials	Medication — Dosage — Frequency — Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial
10/31 JC	Dalmane 30 mg P.O	10/31	9						
	Demerol - 50 mg								
	Vistaril - 50 mg IM	11/1	830	4/SP					
	Atropine 0.4 mg								
	Post-OP- date								

(Use Red Ink)

(PRN ORDERS – SEE REVERSE SIDE)

Doctor Knox Intern Date/Time Admitted 11/3/82 3:30 PM

Age 35 Religion Baptist Date/Time Discharged

Name Smith NANCY

/ _ 121

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SIGNATURE	TITLE	SIGNATURE	TITLE
J.C. Jane Cat	L.P.N		
A.P. Anne Patt	R.N		
S.P. Sue Pat	L.P.N		
J.H. Jane Hop	R.N		

PRN Medications

Nurse giving a PRN medication enters, next to the medication, vertically, the date – time given and initials for each dose given.

Dr Date Initials	Exp. Date Time	Medication — Dosage — Frequency — Rt. of Adm.	DOSES GIVEN Post op - date		Post - op - date
11/1	11/4	~~Demerol 75-100 mgm - IM~~	11/1	11/1	Stop Surgery. Date Hour/Date
		~~q 3-4 hrs~~	7Pm	10am	
		~~PRN Pain~~	S/SP	J/JH.	
11/1	(Use Pencil)	Vistaril 50mg IM	11/1		
		q - 4 hrs	2Pm		
J.H.		PRN - Pain	J/C		
11/3		Percodan - i P.O			
		q - 4 hrs			
J.H.		PRN - Pain			

(Use Red Ink)

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STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare medicine sheets ...{Medication Administration Record}...

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing medicine sheets, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Prepared a medicine sheet ...{Medication Administration Record Form}...					
a. Transcribed appropriate information about medication from physician's order ...{Kardex}... to medicine sheet.	( )	( )	( )	( )	( )
b. Prepared single order and stat order cards if necessary.	( )	( )	( )	( )	( )
2. Secured approval of medicine sheets from charge nurse.	( )	( )	( )	( )	( )
3. Placed medicine sheet in appropriate location.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Prepare requisitions for routine diagnostic tests

PERFORMANCE OBJECTIVE

Given access to required information, supplies and equipment: prepare the routine diagnostic test requisition(s)* for one newly admitted patient. Forms must be accurate, legible, and satisfy posted accreditation requirements. (4)

*Note: South Carolina writing team concluded that the representative hospital in the State considered only CBC as a routine test.

PERFORMANCE GUIDE

1. Determine the tests for which requisitions are to be prepared. Note: This will vary depending upon the type of illness and the hospital's policies, generally includes serology, CBC, UA, and chest X-ray.
2. Select appropriate form(s).
3. Select correct addressograph plate for this patient.
4. Imprint form(s) and fill in requested information, making certain that all duplicates are legible.
5. Prepare UA specimen label and container ...{if applicable to hospital}...
6. Place form(s) in Kardex for charge nurse's initialing.
7. Give labeled UA container to appropriate person.
8. Route the forms when cleared by charge nurse.
9. File the floor copy of the requisition(s).**
10. Enter the information into computer if applicable.

** South Carolina revised version of performance guide #9:
File the verification copy from requisition in pocket on back of patient's chart; remove when report is placed in chart.

LEARNING ACTIVITIES

1. Discuss routine diagnostic tests performed on newly admitted patients.
2. Become familiar with appropriate form for each test (e.g., attached Hematology form.)
3. Practice imprinting names on forms.
4. Study individually the information sheet titled "Patient Care Form (Diagnostic and Miscellaneous Procedures)" (attached).
5. Review attached form associated with the procedures studied in activity 4. An overhead transparency may be used with the entire class asking questions as appropriate.
6. Demonstrate correct method for filling in forms.
7. Practice collectively and individually the transcription of tests to Diagnostic and Miscellaneous Procedures form.

8. Discuss method of routing of requisitions and appropriate destinations.
9. Explain the purpose of the verification copy (attached).
10. Memorize for recall on a teacher-prepared test the different types of routine diagnostic tests performed by the laboratory.
11. Learn from a guest resource speaker (a physician) the answer to the following questions:
    (1) What are the purposes of routine diagnostic tests?
    (2) How do test results aid the physician?
    (3) What is meant by "the normal range of values"?
12. Visit a unit to observe the total process involved in the preparation of requisitions for routine diagnostic tests, from the actual preparation to the filing.
13. Demonstrate mastery of this task by performing the activities for the instructor who will require repetition unless a "fully accomplished" rating can be given the first attempt.

RESOURCES

physician
experienced ward clerk

TOOLS AND EQUIPMENT

sample forms
pens, pencils
addressograph
nameplate

EVALUATION

Using the materials provided, the student will prepare the routine diagnostic requisition form(s) for a newly admitted patient. Accuracy and legibility must be perfectly maintained. The accreditation requirements must be satisfactorily addressed. Demonstration must earn a "fully accomplished" rating by the instructor.

PATIENT CARE FORM

(DIAGNOSTIC AND MISCELLANEOUS PROCEDURES)

DEFINITION AND PURPOSE

The Diagnostic and Miscellaneous Procedures Form is a means of recording diagnostic studies (lab, X-ray, nuclear medicine, and radiation therapy), physical therapy treatments and respiratory therapy treatments.

POLICY

1. Enter only tests and treatments ordered.

RESPONSIBLE PERSONS

RN
LPN
NT
Unit Secretaries

GENERAL INSTRUCTIONS

1. Do not enter other orders, (i.e., call physician about room number, wash patient's hair, etc.) on this form.

2. Enter studies and treatments under appropriate columns.

PROCEDURE

1. Enter order date, initials of person transcribing order, name of test and date test is to be done in the appropriate space.

2. Initial the second **INITIALS** column when the test has been completed.

3. Draw one red line through the order when the test results are posted on the chart.

4. Cross out the title of any section which does not pertain to an individual patient and relabel as needed for additional space, i.e., lab, X-ray.

V - TECS 51
L.A. #5

DIAGNOSTIC & MISCELLANEOUS PROCEDURES FORM

(ADDRESSOGRAPH)

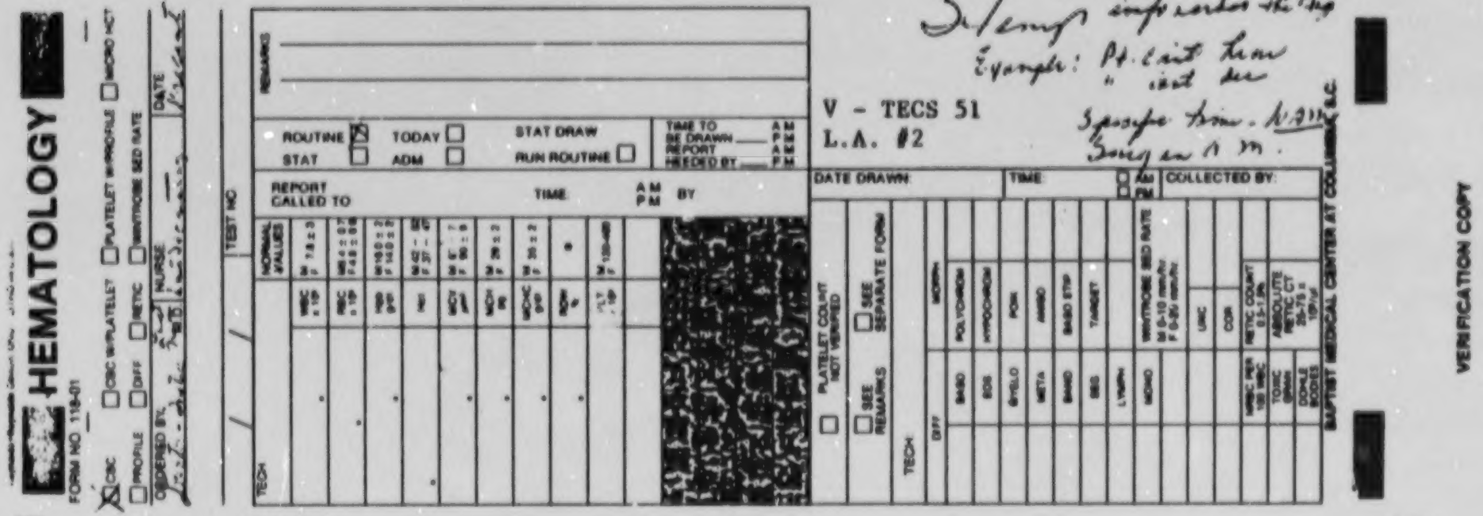
DATE	RN LPN	LAB, EKG, EEG	DATE	NURSE	DATE	RN LPN	X-RAY	DATE	NURSE
[illegible]		[illegible]							

DATE	RN LPN	DAILY LAB, X-RAY, ETC	DATE	NURSE	DATE	RN LPN	PHYSICAL THERAPY	DATE	NURSE

DATE	RN LPN	NUCLEAR MEDICINE/ RADIATION THERAPY	DATE	NURSE	DATE	RN LPN	RESPIRATORY THERAPY	DATE	NURSE

8/80

BEST COPY AVAILABLE



HEMATOLOGY

FORM NO 118-01

☒ CBC ☐ CBC W/PLATELET ☐ PLATELET W/PROFILE ☐ MICRO HCT

☐ PROFILE ☐ DIFF ☐ RETIC ☐ WINTROBE SED RATE

ORDERED BY: NURSE: DATE:

REMARKS

ROUTINE ☒ TODAY ☐ STAT DRAW

STAT ☐ ADM ☐ RUN ROUTINE ☐

TIME TO BE DRAWN ___ AM PM

REPORT NEEDED BY ___ AM PM

REPORT CALLED TO TIME AM PM BY

TEST NO

NORMAL VALUES

TECH

DATE DRAWN: TIME: ☐ AM ☐ PM COLLECTED BY:

☐ PLATELET COUNT NOT VERIFIED ☐ SEE SEPARATE FORM ☐ SEE REMARKS

TECH

DIFF

MORPH POLYCHROM HYPOCHROM POIK ANISO BASO STIP TARGET

BASO EOS MYELO META BAND SEG LYMPH MONO

WINTROBE SED RATE

URIC COR

RETIC COUNT ABSOLUTE RETIC CT

NRBC PER 100 WBC TOXIC GRAN DOHLE BODIES

BAPTIST MEDICAL CENTER AT COLUMBIA S.C.

VERIFICATION COPY

V - TECS 51
L.A. #2

[illegible] Write any helpful info across the top
Example: Pt. can't hear
" can't see
Specific time - [illegible]
Drawn at A.M.

Hematology form must
be completed in triplicate.

BEST COPY AVAILABLE

V-TECS 51
L.A. #13

STUDENT____________________________

DATE____________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare requisitions for routine diagnostic tests.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing requisitions for routine diagnostic tests, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Verified tests to be performed.	( )	( )	( )	( )	( )
2. Selected and prepared proper requisition forms.	( )	( )	( )	( )	( )
3. Prepared specimen label and container if appropriate.	( )	( )	( )	( )	( )
4. Secured nurse's initials.	( )	( )	( )	( )	( )
5. Routed the form and filed the floor copy.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISHCARGE ACTIVITIES

TASK: Institute/change/discontinue diet service

PERFORMANCE OBJECTIVE

Given the patient's chart, Kardex, ...(or patient care form)... and the diet worksheet*, institute, change, or discontinue diet service. Notification must be made to the dietary department at the time specified. No errors or omissions will be acceptable as determined by the supervisor's findings. (4)

(*South Carolina writing team chooses different term: diet order requisition.)

PERFORMANCE GUIDE

1. Determine kind of diet patient is to receive.
2. Place information on diet sheet, worksheet, and Kardex.
3. Notify dietary department of admission, discharge, or transfer needs.
4. Check for any lab, X-ray, operative procedures, or religious observances which would require special diets or alterations of food services.
5. Notify dietary department of any diet changes, holds, NPO's or special diets using standard communications procedure in time to prevent waste of food and effort.
6. Enter information into computer if applicable.

LEARNING ACTIVITIES

1. Tour the dietary department in a local health care facility. Observe the responsibilities of the dietary personnel and the procedures they follow when a dietary order is received in their department.
2. Research the different types of diets and prepare a 3-columned chart depicting a) type of diet, b) description, and c) common purpose. Compare with classmates and prepare a composite chart to be learned by everyone as homework assignment.
3. Distribute information sheet titled "Dietary Diet Order Requisition" and demonstrate correct procedure for placing diet on forms.
4. Demonstrate correct procedures for notifying dietary department of admission, discharge or transfer needs (i.e., call dietary department, give name and unit, name of patient and room number, relay needs).
5. Role play a typical situation as demonstrated in learning activity #4.
6. Visit a unit in order to learn where Dietary Diet Order Requisition is posted for dietary personnel to pick up.
7. While visiting unit, listen to a ward clerk as he/she reviews physician's orders for special restrictions.

8. Demonstrate through role play the correct procedure for notifying dietary department of any diet changes, holds, NPO's, or special diets. (Refer to parenthesis in learning activity #4.)
9. Demonstrate mastery of the task by performing it for the instructor until a rating of "fully accomplished" is achieved.

RESOURCES

dietary department personnel

TOOLS AND EQUIPMENT

appropriate forms
pencil

EVALUATION

Using provided materials and information, the student will institute/change/discontinue diet service. Notification must follow the established procedures. No errors or omission can be allowed. Demonstration for the instructor must earn a "fully accomplished" rating.

DIETARY DIET ORDER REQUISITION

CARBON NOT REQUIRED

BY: ______________________ R.N.

FLOOR: ______________________

DATE: ______________________

V - TECS 41
L. A. #2

A.M.: 4:30
CALL TIME – D&S
9:30 A.M. & 12:30 P.M.

ROOM NO.	NAME	HOLD, ECT.	FULL (REGULAR)	SOFT	LIQUIDS		SPECIAL DIETS	DINNER CHECK	SUPPER CHECK
					SURG.	FULL			

BEST COPY AVAILABLE

Reynolds+Reynolds CELINA OHIO LITHO IN U.S.A.

V-TECS 41
L.A. #9

STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Institute/change/discontinue diet service.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When instituting/changing/discontinuing diet source, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Verified patient's diet.	( )	( )	( )	( )	( )
2. Placed information on diet sheet, worksheet and Kardex.	( )	( )	( )	( )	( )
3. Notified dietary department of any diet change.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Clerically admit patients

PERFORMANCE OBJECTIVE

Given the required information, equipment, and supplies and an incoming patient, perform clerical activities associated with admission without error or omission of any detail listed in the local ward clerk manual. (4)

PERFORMANCE GUIDE

1. Introduce self and greet patient in a reassuring, unhurried manner, with a smile and a pleasant tone of voice. Note: Be sincere; patients quickly detect insincerity. The impressions created at this point have far reaching implications.
2. Verify accuracy of information on the admission summary sheet, ID band, and addressograph plate.
3. Obtain a chart packet.
4. Imprint all the chart forms with the patient's name.*
5. Select and label the correct chart back using physician's color code if applicable.
6. Insert the chart forms in the proper sequence into the chart back within its dividers according to the established policy. The chart becomes a legal document at this time.
7. Place the chart in the chart rack.
8. Update all posted lists, worksheets, unit records.
9. Notify all concerned departments and persons of admission.
10. Initiate the nursing admission history form.
11. Identify and prepare labels for each item belonging to, or which will be used by the patient:** Bed, room, bedside tables, medicine drawer or box, water carafe, bed pan, urinal, face basin, denture cup, emesis basin, clothing, etc. This may include dating for certain items such as water carafe and drainage bags. The hospital shall be equipped, operated, and maintained so as to sustain its safe and sanitary characteristics and to minimize all health hazards in the hospital, for the protection of both patients and employees. **J.C.A.H. Standard II**, "Environmental Services."

* South Carolina writing team suggests the following addition to performance guide #4:

Note: If patient has any abnormalities (i.e., blind, deaf, aged, irrational, etc.), write in red ink on front of chart and on all diagnostic or therapeutic requisitions.

** South Carolina writing team concludes that the identification and preparation of labels is a responsibility of the nursing staff.

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LEARNING ACTIVITIES

1. Observe demonstration of instructor; then practice with classmate the introduction of self (i.e., name, unit, job title).
2. Research how one verifies the information on admission summary sheet, ID band, and addressograph plate.
3. Visit a unit to observe where chart packets and chart backs are kept. Discuss each form individually. (Sample admission packets and surgery packets are attached for independent or group study.)
4. Review information sheet titled "Policy on Patient Admission."
5. Practice imprinting chart forms.
6. Demonstrate correct procedure for labeling chart back (i.e., patient's last name, physician's last name and initials, flagging for allergies).
7. Review all chart forms and observe demonstration of proper sequencing, including explanation of use of chart dividers. (Refer to admission and surgery packets studied in learning activity #3.)
8. Review by listing on board the procedures learned up to this point for performing admission activities.
9. Demonstrate correct procedure for initiating Patient History and Nursing Observation form. (Sample is attached.)
10. Role play the notification of appropriate departments and persons about admission of a patient.
11. Take a teacher-prepared test about the responsibilities of the ward clerk in clerically admitting patients.
12. Simulate the steps one would take in clerically admitting a patient. Necessary patient information will be provided for the simulation. The instructor will evaluate the simulation according to the items listed on the instructor's checklist.

TOOLS AND EQUIPMENT

appropriate forms
ID band
addressograph plate

EVALUATION

Using materials provided, the student will perform clerical admission procedure without any errors. Demonstration must warrant a rating of "fully accomplished" on the instructor's checklist.

V-TECS 47
L.A. #3

ADMISSION PACKET

The newly admitted patient's chart consists of the following eight forms. Stamp these forms with the name plate when admitting the patient.

Chart Forms

1. Graphic Sheet/intake-output record	
2. Doctor's orders	Doctor's orders
3. Progress Notes	Medical
4. Hematology (C.B.C.)	Diagnostic
5. Chemistry (S.M.A.)	Diagnostic
6. Miscellaneous Lab	Diagnostic
7. Profile	Nurse's Section
8. Interdisciplinary	Nurse's Section
	Miscellaneous

V - TECS 47
L. A. #3

E.R.? 81
O.P.? 81
Admitted through E
Non-Smoker

PATIENT'S CHART
NO STAMP

HOSP NO 411702-8 DISCHG DATE ROOM BED
ADM CLK alm/ ADMIT DATE 09-14-82 ROOM BED 324-1 ADM TIME 14:00
TYPE ADM ELEC ☐ URGENT ☐02 ADMITTED O.P. ☐ E.R. ☐05 OTHER ☐

Doe FIRST NAME Mr. John MIDDLE MAIDEN T.
1900 Marion St. CITY STATE Cola. S.C. 29202 LOCATION CODE 40
Richland ADMITTING DIAGNOSIS Headaches ADMIT SERVICE NO 01
RMH 81 DATE OF PREV ADM 01-82 REFERRING DR CODE ATTENDING DR CODE 5103
000-00-0000 HOME PHONE 771-5010 SEX Male(W) MARITAL STATUS Married
Richland BIRTH STATE S.C. AGE 29 BIRTH DATE 07-04-53
☐.☐ First Bapt. RELIGION Baptist RELIGION CODE 06
ATTENDING PHYSICIAN Dr. P. Williams PAT EMP CODE
State of S.C. CITY STATE Cola. S.C. PHONE 758-0000
Wife CITY STATE Cola. S.C. PHONE 771-5010
Mrs. Mary Doe CITY STATE Cola. S.C. PHONE 771-5010
Homemaker CITY STATE Cola. S.C. PHONE 771-5010
John & Jane Doe CITY STATE PHONE

AND TREATMENT, ALSO BRIEF DESCRIPTION AT DISCHARGE)

DATE

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V - TECS 47
L. A. #3

GRAPHIC/INTAKE - OUTPUT RECORD

(ADDRESSOGRAPH)

DATE															
HOSP. DAY/PO-PP															
HOUR		A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
		12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8
CHART PULSE IN RED	CHART TEMPERATURE IN BLUE														
140	105														
130	104														
120	103														
110	102														
100	101														
90	100														
80	99 Normal														
70	98														
60	97														
50	96														
RESPIRATIONS															
BP	S														
	D														
Weight Urine Stools															
B'Fast Lunch Dinner															
Other Dietary Intake															

DATE	INTAKE				OUTPUT			
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

DATE	INTAKE				OUTPUT			
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

DATE	INTAKE				OUTPUT			
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

FORM N4(2)-216-79

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DOCTOR'S ORDERS

V - TECS 47
L. A. #3

PHYSICIAN'S ORDERS

AUTOMATIC STOP ORDER: SCHEDULE OF STOP DATES REPRODUCED BELOW IS IN TERMS OF DAYS FOLLOWING DATE OF ORIGINAL ORDER. IF STOP DATE FALLS ON SUNDAY OR HOLIDAY ORDER EXTENDED ONE DAY. TIME 11:00 A.M.

THIS ORDER DOES NOT APPLY WHEN PHYSICIAN'S ORDER INDICATES EXACT NUMBER OF DOSES AND/OR DAYS TO BE ADMINISTERED.

ANTIBIOTICS. 7
SCHEDULE III MEDICATIONS 7
SCHEDULE II MEDICATIONS. 3

DO NOT WRITE IN THIS SECTION IF RED ↓

(✓)	START → HERE	DATE	TIME A.M. P.M.	ALLERGIES:	(1)

M.D. DISPENSE AS WRITTEN
M.D. SUBSTITUTION PERMITTED

(ADDRESSOGRAPH)

DO NOT WRITE IN THIS SECTION IF RED ↓

(✓)	START → HERE	DATE	TIME A.M. P.M.	ALLERGIES:	(2)

M.D. DISPENSE AS WRITTEN
M.D. SUBSTITUTION PERMITTED

(ADDRESSOGRAPH)

DO NOT WRITE IN THIS SECTION IF RED ↓

(✓)	START → HERE	DATE	TIME A.M. P.M.	ALLERGIES:	(3)

M.D. DISPENSE AS WRITTEN
M.D. SUBSTITUTION PERMITTED

(ADDRESSOGRAPH)

MEDICAL

V - TECS 47
L. A. #3
Stamp with Addressograph

HOSPITAL

Addressograph

Date	Notes should be signed by Physician

PROGRESS NOTE

Form MS-5[illegible]

STAMP - PATIENT'S NAME PLATE
ADDRESSOGRAPH

V - TECS 47
L. A. #3

This "Dear Doctors" form would then be placed in chart under the miscellaneous divider when History & Physical's completed. The two History & Physical sheets placed under the Medical Section of the Patient's chart.

(Date)____________________197___

KNOW: Phone Administration when a patient is scheduled for surgery and a H&P has not been completed and on the chart!!!

Dear Doctor:

This is a reminder that your patient,____________________________, has been hospitalized for forty-eight hours and as yet a history and physical has not been written nor dictated.

Please complete the history and physical as soon as possible.

Thank you for your cooperation.

Chairman
Medical Record Committee

HISTORY &
PHYSICAL DONE

HISTORY &
PHYSICAL NEEDED

Tapes - On Unit:
Place over the end
of chart, as needed

V - TECS 47
L. A. #3

CASE HISTORY

Personal: Age ________ Sex ________ S. M. W. D. ______ Occupation ____________

Family History: ____

Habits and Social History: ____________________________________

Past Medical History (Injuries, Operations, Hospitals, System Review) ______________

History of Present Illness (Onset, Duration, Cause) ______________________

Physical Examination: Height ________ Weight ________ Nutrition ____________

Temp. ________ Pulse ________ Resp. ________ Blood Press. S. ______ D. ______ P.P. ______

Head: (including eye, ear, nose, mouth and throat) ______________________

Form MS-5(1)-2A 2/84

V - TECS 47
L. A. #3

CASE HISTORY

Thorax and Lungs: ____________________

Heart: (vascular system) ____________________

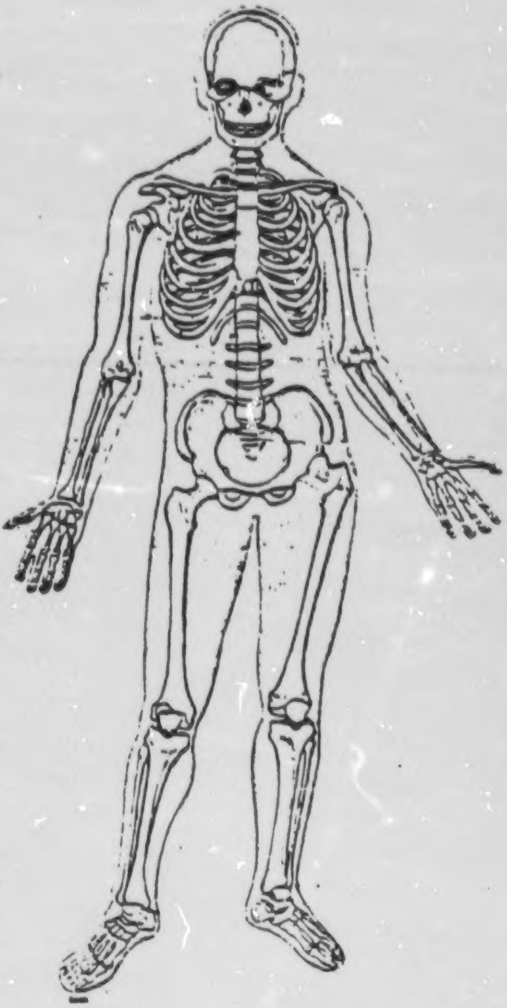
Abdomen: ____________________

Genito-Urinary: (Including female pelvis) ____________________

Neuro-Muscular: (Including Extremiti[illegible] ____________________

Skin: ____________________

Special Examination: ____________________



Tentative Diagnosis: ____________________

Date ______________ Examined by ____________________

Form MS-5(1)-2B 2/84

DIAGNOSTIC

MOUNT ONLY COULTER HEMATOLOGY REPORTS ON THIS SHEET

PLACE FIRST REPORT HERE

REMOVE TAPE STRIPS AND ATTACH FIRST REPORT IN THIS AREA. ADDITIONAL REPORTS SHOULD BE ATTACHED IN SHINGLED FASHION

2

3

4

5

HOSPITAL FORMS

BEST COPY AVAILABLE

HEMATOLOGY LABORATORY REPORTS

1

2

3

156

MISCELLANEOUS LAB MOUNT SHEET

V - TECS 47
L. A. #3

1 **2** **3**

149 157

SMA MOUNT SHEET

HOSPITAL FORMS

NURSES SECTION

V - TECS 47

L. A. #3

MEDICATIONS (DIRECTIONS)

RET

AMOUNT

151

159

160

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MEDICAL RECORDS

V - TECS 47
L. A. #3

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ACTIVITY SHEET

DATE ____________________ (ADDRESSOGRAPH)

SHIFT	11-7 A.M.	7-3 P.M.	3-11 P.M.
HYGIENE			
ACT. SLEEP REST			
SAFETY			
NUTRITION			
ELIMINATION			
ASSESSMENT			
PSYCHOSOCIAL/PATIENT EDUCATION			
NURSE'S SIGNATURE			

INTERDISCIPLINARY PROGRESS NOTES

Date & Time

Form N4(2)-5 (5/73)

MISCELLANEOUS

V - TECS 47
L. A. #3

All Entries Must Be Printed

Medication Administration Record

Enter Here IN PENCIL Number of Forms in Use ☐

Name

Case No.

Room No.

Diagnosis

Surgery

Allergic Test
(Record in Red)

DATES GIVEN

Form No.

Off Date Initials	Exp. Date Time	Medication—Dosage—Rt. of Adm.	HR.														

SINGLE ORDERS – PRE-OPERATIVES

Enter here in pencil No. of Forms in use ☐

Off Date Initials	Medication — Dosage — Rt. of Adm.	To Be Given		Nurse Initial	Off Date Initials	Medication — Dosage — Frequency — Rt. of Adm.	To Be Given		Nurse Initial
		Date	Time				Date	Time	

(PRN ORDERS – SEE REVERSE SIDE)

Doctor ____________ Intern ____________ Date/Time Admitted ____________

Age ______ Religion ____________ Date/Time Discharged ____________

Name ____________

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SIGNATURE	TITLE	SIGNATURE	TITL

PRN Medications

Nurse giving a PRN medication enters, next to the medication, vertically, the date – time given and initials for each dose given.

Dr Date Initials	Exp. Date Time	Medication — Dosage — Frequency — Rt. of Adm.	DOSES GIVEN

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(DIAGNOSTIC & MISCELLANEOUS PROCEDURES FORM)

(ADDRESSOGRAPH)

DATE	RN LPN	LAB, EKG, EEG	DATE	NURSE	DATE	RN LPN	X-RAY	DATE	NURSE

DATE	RN LPN	DAILY LAB, X-RAY, ETC	DATE	NURSE	DATE	RN LPN	PHYSICAL THERAPY	DATE	NURSE

DATE	RN LPN	NUCLEAR MEDICINE/ RADIATION THERAPY	DATE	NURSE	DATE	RN LPN	RESPIRATORY THERAPY	DATE	NURSE

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FOR: Appendectomy Post ICU Gastrectomy Abdominal Surgery, Adult
Hernia Exploratory Laparptory
Pilonidal Cyst Cholecystectomy

V - TECS 47
L. A. #3

Admission Date ________ BATH: Self Assist Bed
Classification ________
Diet ________
Diet ________
Diagnosis ________
Surgery ________ Page 1

Attending Physician(s):
________ ________
________ ________
(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			1.A. Vital signs (T, P, R, and BP) every 4 hrs. x 72 hours.	Afebrile (temp less than 99.6 24 hrs. prior discharge.
			B. DC at _____ am/pm on ________. Then routine q ________ hrs.	
			C. Turn, cough, deep breathe every 2 hrs. x 24 hours. (Do not cough hernia patient.) Assist patient to splint incision as necessary.	
			2.A. Check dressing(s) every 4 hrs. x 24, then QID	Clean healing wound.
			B. If prn dressing change order: Change dressing at least daily to observe wound area for redness, swelling, increased drainage, healing.	
			C. Note presence of:	
			Drain ________ Removed ________	
			Skin clips ________ Remove ________	
			Staples ________ Remove ________	
			Sutures ________ Remove ________	
			Steri-strips ________	
			T-tube ______ Empty ______ Removed ________	
			Hemovac ______ Empty ______ Removed ________	
			Other ________	

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PRE-OPERATIVE PATIENT FOR ADULT SURGERY

V - TECS 47
L. A. #3

Admission Date ______ BATH: Self ˉAssist Bed
Classification ______
Diet ______
Diet ______
Diagnosis ______
Surgery ______

Attending Physician(s):

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			Vital signs (T, P, R, and BP) on admission and @ HS prior to surgery and AM of surgery. Prepare for surgery as ordered:	Afebrile (less 99.6) 12 hours prior to surger Establishment c baseline vital signs.
			Up ad lib unless contraindicated.	Ambulatory
			1. Give verbal and/or written explanation of preparation for surgery and of post-op care.	Verbalizes instructions regarding proce-dures and coope with plan of ca
			2. Explain operative permit to patient and witness patient's signature.	Informed consen

FOR: Appendectomy Cholecystectomy Abdominal Surgery, Adult
Hernia Post ICU Gastrectomy
Pilonidal Cyst Exploratory Laparotomy

V - TECS 47
L. A. #3

Admission Date ______ BATH: Self Assist Bed

Classification ______

Diet ______

Diet ______

Diagnosis ______

Surgery ______ Page 2

Attending Physician(s):

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			3.A. I & O every 8 hrs. ______	Normal bladder
			B. DC at ______ am/pm on ______	function restor
			if voiding freely and taking po fluids.	
		(Cath order)		
			4. Levine tube ______ Salem sump ______	Bowel function
			Connect to ______	restored (1 BM
				prior to discha
			Irrigate with ______	Tolerating diet
			Remove NG tube (date) ______	
			5.A. Elevate foot of bed 3" x 8 hrs. (if ordered)	
			B. Lower foot of bed at ______ am/pm	
			on ______.	
		(Ambulation orders)		Ambulatory

Hernia Post ICU Gastrectomy
Pilonidal Cyst Exploratory Laparotomy

V - TECS 47
L. A. #3

Admission Date ____ BATH: Self Assist Bed

Classification ____

Diet ____

Diet ____

Diagnosis ____

Surgery ____ Page 3

Attending Physician(s):

____ ____

____ ____

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			Discharge ____	
			6. Instruct patient and/or significant other	
		Date and Initials	in the following:	Patient verba
		____	A. Follow-up appointment ____	understanding
		____	B. Activity limitations	or demonstrates
		____	C. Wound Care	discharge instr
		____	D. Take home drugs	tions.
			E. Special diet	
			Reinforce physician's instructions	

BEST COPY AVAILABLE

V-TECS 47
L.A. #3

SURGERY PACKET

Stamp these five forms with the patient's name plate and place on the front of the chart, when a patient goes to surgery.

1. Consent
2. Frequent observation
3. Anesthesia Record
4. Pre-op Checklist
5. Fluid Administration

V - TECS 47
L. A. #3

CONSENT TO OPERATION, ANESTHETIC AND OTHER MEDICAL SERVICES

Date____________________________

Time____________________________ am
pm

1. I authorize the performance upon ____________________________ (myself or name of patient)

   of the following operation ____________________________ (state nature and extent of operation)

   to be performed under the direction of Dr. ____________________________ and/or such assistants as may be selected by him to perform such operation.

2. I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures or services than those set forth above and I further authorize and request that the above-named surgeon and/or his associates, partners, assistants or designees perform such procedures as are, in his professional judgement, necessary and desirable.

3. I consent to the administration of such anesthetics as may be considered necessary or advisable by the person responsible for such service.

   State any known anesthesia allergies:____________________________

4. I consent to the disposal by hospital authorities of any tissue or members which may be removed during the course of the operation.

5. The nature, purpose and possible consequences of the operation, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me by my attending physician and/or surgeon. No guarantees or assurances have been made or given by anyone as to the results that may be obtained.

6. I, THE UNDERSIGNED, HAVE HAD THIS FORM EXPLAINED TO ME AND FULLY UNDERSTAND THE CONTENTS OF THIS AUTHORIZATION.

Signed____________________________
(patient or authorized person)

Witness____________________________ ____________________________
(relationship)

FREQUENT OBSERVATION RECORD

(ADDRESSOGRAPH)

Date/ Hour	Blood Pressure		Pulse	Resp.	Temp.	INTAKE			OUTPUT		
						I.V.	Other		Urine	Other	

FORM N4(2)-4 (4/79)

V - TECS 47
L. A. #3

ANESTHESIA RECORD

Date	NPO	PHYS. STATUS

PREMEDICATION (DRUGS, DOSE, TIME, EFFECT)

BUSINESS DATA PLATE

15 30 45 15 30 45 15 30 45 15 30 45 15 30

Agents N_2O O_2

FLUIDS

BLOOD LOSS

	°C	
B.P. V Λ		240
Pulse •	38	220
	36	200
Start Anes. X	34	180
Start Op. ⊙	32	160
	30	140
End Anes. ⊗		120
Temp Δ		100
		80
Suct. S		60
		40
Rec. Room R		20
Resp. O	Spon. Asst. Cont.	10

SYMBOLS

AGENTS	DOSAGE	TECHNIQUES
A.		
B.		
C.		
D.		
E.		
F.		
G.		

Monitors: BP ______________ Stethoscope __________ EKG BAM

Temp ________ foley, CVP, Swan Ganz, O_2 Monitor

Airway/endotracheal tube ______________

FLUID SUMMARY	BLOOD LOSS
	URINE
	Anesthesia Time

OPERATION

SURGEON

ANESTHESIOLOGIST

Form 20-881-001 (Rev. 1/82)

V - TECS 47
L. A. #3

PRE-ANESTHESIA EVALUATION

Date: ______________ Proposed Operation ______________

Age: ______________ Weight:

PERTINENT HISTORY AND PHYSICAL FINDINGS

[illegible]

NO	YES	
☐	☐	**CARDIOVASCULAR** (MI, Angina, CHF, Valvular, High BP) ______________
☐	☐	**PULMONARY DISEASE** (Asthma, COPD) ______________
☐	☐	**CNS, NEUROMUSCULAR** (CVA, Seizures, Mental status) ______________
☐	☐	**RENAL DISEASE** (Kidney failure) ______________
☐	☐	**HEPATIC DISEASE** (Hepatitis, Cirrhosis) ______________
☐	☐	**ENDOCRINE** (Diabetes, Thyroid) ______________
☐	☐	**HEMATOLOGICAL** (Anemia, Sickle cell, Bleeding disorder) ______________
☐	☐	**ORAL CAVITY** (Loose teeth, Dentures, Difficult Airway) ______________
☐	☐	**PREVIOUS PROBLEMS WITH ANESTHESIA** ______________
☐	☐	**ALLERGIES TO MEDICATIONS** ______________
☐	☐	**CURRENT MEDICATIONS** ______________
☐	☐	**OTHER** ______________

PERTINENT LAB:

ASA PHYSICAL STATUS: CLASS 1, 2, 3, 4, 5, E

ANESTHETIC PLAN: PATIENT AGREES TO: ______________

______________, M.D.

CONDITION ON ADMISSION TO PAR

LEVEL OF CONSCIOUSNESS	RESPIRATORY EFFORT	AIRWAY	VITAL SIGNS
Awake	Adequate	Adequate airway	BP
Arousable on calling	Inadequate	Oral or nasal airway	P
Not responding	Ventilator	Endotracheal tube	R

APPARENT COMPLICATIONS

____

______________ CRNA

______________, MD

V - TECS 47
L. A. #3

PRE-OPERATIVE CHECK LIST **Nurse's Initials**

1. Operative permit signed and properly witnessed. ____
2. CBC on chart. ____
3. Urinalysis on chart. ____
4. Physician notified of abnormal lab/x-ray reports. ____
5. Bleeding and coagulation time on chart of T&A patient, (if ordered). ____
6. Blood typed and crossmatched. Yes ____ No ____ Units ____
7. History and physical exam on chart ____ or dictated ____
8. Notify PM Administrator if H&P not on chart by 9 p.m. ____
9. Consultation sheet signed and on chart as required by hospital policy. ____
10. Special permits signed and properly witnessed as required by hospital policy. ____
11. Religion of patient is ____
12. Anesthesia sheet on chart. ____
13. Pre-op teaching done. Peds party ____ GYN class ____ Individual ____
Date ____ PM/Night Nurse's Signature ____
14. Identification bracelet on and legible ____
15. TPR and BP are charted. ____
16. Cosmetics, hairpins, hairpieces, wigs, artificial eyelashes removed. ____
17. Dentures ____ Partial Plates ____ Bridges ____ Caps ____
18. Contact lens Yes ____ No ____ Placed ____
19. Mouth checked for chewing gum, mints, etc. ____
20. Jewelry Yes ____ No ____ Placed ____
21. Complete recheck of doctor's pre-operative orders. ____
22. Addressograph plate with chart. ____
23. MAR on chart. ____
24. Patient care form on chart. ____

R4/84

Nurse's Initials

25. Urinary bladder emptied ___ Catheter inserted ___

26. All nail polish removed from nails ___

27. Re-check operative permit prior to pre-op being given. ___

Date ___ Night/AM Nurse's Signature ___

OR-HOLDING ROOM

28. Patient received in Holding Room at am/pm ___

29. Shave completed by ___

30. Chart checked by ___ and ___
Holding Room Personnel Circulating Nurse

V - TECS 47
L.A. #3

FLUID ADMINISTRATION FORM

Addressograph

DATE	TIME	NURSE	SOLUTION-BLOOD	NEEDLE/DEVICE & SIZE, SITE	RATE	AB-SORBED	IV TUBING CHANGED	COMMENTS

DATE	INITIALS	IV FLUIDS AND BLOOD ORDERS

POLICY ON PATIENT ADMISSION

NOTE - The patient will bring to the unit from the admitting office the following three (3) items, the face sheet, addressograph plate and a Hematology requisition.

PATIENT ADMISSION

1. Place addressograph plate into holder with assigned room number on it.

2. Stamp chart & surgery form (if needed) the M.A.R., Patient Care Form, Lab & Diagnostic procedure form. Complete dateline and information on M.A.R. and P.C.F. Place chart into appropriate chart holder. The M.A.R. goes in the Kardex, the P.C.F., Lab & Diagnostic and Fluid Administration (if needed) are kept in the Patient Care Notebook.

3. Stamp the Patient's Medication Profile Record. Record the allergy (in red) and the diagnosis from the face sheet. Send to the Pharmacy.

4. Leave the Profile Sheet on the desk top for the NA to complete the admission process.

5. Stamp and complete Hematology and Urinalysis Slips if the Physician orders UA. If the test needs to be run at a specific time or if the patient is scheduled for surgery, write this information across the top of the requisition. (Check surgery schedule.)

6. Complete the graphic sheet. Chart the vital signs, BP, and weight from the Profile Sheet.

7. Complete information and datelines on all of the above forms.

8. Label the chart using name tape (use magic marker). Put the patient's last name and the Physician's last name, write the patient's first name on a small piece of tape if the patient is scheduled for surgery.

9. Record allergy or "none known" (in red) from the profile to the M.A.R. and Physician order and flag the chart with allergy tape if needed.

10. Stamp a medicine card for chart rack. At bottom write doctor's last name and date. Stamp a white strip for the brewer cart, to use to identify medicine drawer. Stamp a charge card for SPD cart.

11. Transcribe Doctor's Orders.

12. Send completed requisition to the appropriate departments. Phone diet order to dietary. Phone to schedule treatment or test when necessary. Send the verification from the Doctor's Order sheet to Pharmacy to obtain the patient's medications. Pull verification from requisitions and place in chart or Patient Care Notebook packet.
13. Leave transcribed orders with requisitions in the chart (bracket the orders). Put your initials and time and leave for the nurse to check and initial.
14. Notify attending Physician(s) of patient's room number.
15. Chart admission into census book.
16. Face Sheet: Back - Consents to be signed by patient or relations and witnessed.

NOTE: Notify "Orders for New Admissions" if the patient has or has not brought orders with them at #5629.

When the patient brings medication from home, complete a Patient Personal Medication form #2060. Put medication in envelope which is attached to the back of the form and send to the Pharmacy.
Please read instructions on form.

V - TECS 47
L.A. #9

PATIENT HISTORY AND NURSING OBSERVATION

(ADDRESSOGRAPH)

SECTION I

ADMISSION DATA

DATE ______ HOUR ______
MODE OF ARRIVAL ______
ACCOMPANIED BY ______
TPR ______ BP ______
HT ______ WT ______
VALUABLES: RINGS ______
WATCH ______
MONEY ______
OTHERS: ______

ROOM ORIENTATION

INTRODUCED TO HOSPITAL HANDBOOK ______
CALL LIGHT AND BEDSIDE CONTROLS ______
BATHROOM AND SHOWER ______
VISITING RULES ______
SMOKING POLICY ______
SIDERAIL POLICY ______
IDENTIFICATION BAND ON ______
MEAL TIMES ______

PROSTHESIS: DENTURES ______
CAPS ______
CONTACT LENS: ______
UPPER LIMB ______
LOWER LIMB ______
GLASSES ______
ARTIFICIAL EYE: R ______
L ______
HAIRPIECE ______

DISPOSITION OF VALUABLES ______
HOW CAN FAMILY BE REACHED DURING HOSPITALIZATION? ______

SIGNATURE OF RN OR LPN COMPLETING SECTION I: ______

SECTION II

PRESENT ILLNESS

REASON FOR HOSPITALIZATION ______
ONSET/DURATION ______

ILLNESSES

PREVIOUS ILLNESSES/HOSPITALIZATION	DATES	SURGERIES	DATES

CHRONIC DISEASES (DIABETES, ASTHMA, HYPERTENSION, EMPHYSEMA, HEART DISEASE, GLAUCOMA, SEIZURES)

MEDICATION HISTORY

MEDICATION	DOSAGE	TIMES USUALLY TAKEN-CIRCLE THOSE TAKEN TODAY

MEDICATION DISPOSITION: ______

ALLERGIES SENSITIVITIES

ALLERGIES AND SENSITIVITIES: (FOOD, DRUG, X-RAY CONTRAST MEDIUM, ETC.)
(RECORD IN RED)
DESCRIBE REACTION

SIGNATURE OF LPN OR RN COMPLETING SECTION II: ______

BEST COPY AVAILABLE

SECTION III
NURSING OBSERVATIONS

SKIN: (REDNESS, BRUISES, SWELLING, BROKEN AREAS, RASH, DRY, COLOR, TEMPERATURE OF SKIN)

NEURO: (ALERT, ORIENTED, SPEECH, DIZZINESS)

RESPIRATORY: (SHORTNESS OF BREATH, COUGH, SPUTUM, HISTORY OF SMOKING)

CARDIOVASCULAR: (CHEST PAIN, HEART RHYTHM - REGULAR, IRREGULAR, VARICOSE VEINS, PULSES)

GI: (DISTENDED ABDOMEN, ELIMINATION PATTERNS, APPETITE, NAUSEA, VOMITING, DIFFICULTY SWALLOWING, USUAL DIET)

GU: (FREQUENCY, PAIN, COLOR OF URINE, DISCHARGE)

GYN: (MENSTRUAL HISTORY, VAGINAL DISCHARGE OR BLEEDING)

EENT AND MOUTH: (VISUAL OR HEARING PROBLEMS, BLEEDING GUMS, HOARSENESS)

EXTREMITIES: (EDEMA, MOVES ALL EXTREMITIES, COLOR OF NAIL BEDS)

OTHER ASSESSMENTS: (PSYCHOLOGICAL AND SOCIOLOGICAL)

PATIENT PROBLEMS: (INCLUDE ANTICIPATED PROBLEMS AND LEARNING NEEDS)
1.
2.
3.
4.
5.

SIGNATURE OF RN COMPLETING SECTION III:

V-TECS 47
L.A. #12

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Clerically admit patients.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When clerically admitting patients, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Introduced self and greeted patient in a reassuring, unhurried manner, with a smile and pleasant tone of voice.	( )	( )	( )	( )	( )
2. Verified accuracy of information on the admission summary sheet, ID band and addressograph plate.	( )	( )	( )	( )	( )
3. Obtained a chart packet and chart back from chart wheel.	( )	( )	( )	( )	( )
4. Imprinted all forms with patient's name.	( )	( )	( )	( )	( )
5. Labeled the chart holder correctly.	( )	( )	( )	( )	( )
6. Inserted chart forms in proper sequence to include dividers.	( )	( )	( )	( )	( )
7. Updated all posted lists, worksheets, unit records.	( )	( )	( )	( )	( )
8. Notified all concerned departments and persons of admission.	( )	( )	( )	( )	( )
9. Initiated the nursing admission form.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Transcribe admission orders

PERFORMANCE OBJECTIVE

Having access to all needed forms and information, and given three new admissions with data from the admitting office, transcribe the physician's orders **without error**. The charge nurse must initial the forms prepared, indicating acceptability of transcription. (4)

PERFORMANCE GUIDE

1. Inspect new admission data for doctor's orders.
2. Notify charge nurse if the doctor failed to write orders.
3. Call the doctor ...{New Admission for Orders office}... so that the nurse may obtain orders.
4. Interpret physician's handwriting and transcribe orders accordingly. Note: If orders are written on physician's prescription blank, they must be transcribed ...{taped}... to the doctor's order sheet.
5. Read the entire set of orders before starting to transcribe. Note: "Transcribe" means read and interpret the intent of the order and write this information on all required forms or call for required services, thus notifying others to create the specified activity.
6. Interpret the intent of each order, noting each step.
7. Notify the charge nurse of all STAT orders, and call the concerned department.
8. Establish priorities, consulting charge nurse.
9. Select **all** the forms needed to institute the activity specified in the admission orders, including Kardex cards, medicine or treatment tickets, lists.
10. Identify and prepare the routine diagnostic requisitions for this patient.
11. Complete all forms, making certain that duplicates are legible.
12. Make certain that all associated preparation orders are legible.
13. Proofread all transcriptions and present **all** forms to the charge nurse for approval and signature.
14. Route all forms after they are initialed by the charge nurse.
15. Place appropriate symbols on the order sheet to indicate processing of orders.*

* South Carolina writing team suggests the following revision of performance guide #15: Bracket orders, placing name and title and the time of completion to the left of the order sheet.

LEARNING ACTIVITIES

1. Review sample Patient Admission Policy (attached).

2. Discuss the data which a patient should have upon arrival to unit (i.e., face sheet, admission bracelet, addressograph plate, physician's orders, verification copy(ies) of any diagnostic work done.
3. Discuss and write on board the procedure for obtaining orders from New Admission for Orders office (i.e., identify self: name, title and unit; identify patient and patient's physician(s).) A nurse from this office will bring orders to floor.
4. Demonstrate in small groups the procedure for taping prescription blank to physician's order sheet.
5. Review, by using the overhead projector, the following procedures in addition to the form for each: "Graphic Intake/Output," "Medication Administration Record," "Diagnostic/Miscellaneous Record." Time for questions and answers should be allowed. (Refer to Lesson 11, V-TECS OBJ. 40; Lesson 15, V-TECS OBJ. 50; Lesson 16, V-TECS OBJ. 51.)
6. Review in small groups appropriate diagnostic forms needed for tests according to physician's orders. Time for questions and answers should be allowed.
7. Review as a class the symbols and methods which are necessary in order to accurately transcribe admission orders.
8. Memorize the symbols and methods as a homework assignment.
9. Practice completing the transcription of each found on the attached sample. (An overhead transparency may be used.)
10. Observe an experienced ward clerk in a unit as he/she transcribes admission orders.
11. Demonstrate mastery of transcribing admission orders by accurately following the steps outlined in the instructor's checklist.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms
physician's order
pens and pencils
overhead projector and transparencies

EVALUATION

Using materials provided, the student will transcribe the admission orders for three patients. The transcription must be without error. The student will follow the steps listed in the instructor's checklist and will achieve a rating of "fully accomplished."

NOTE - The patient will bring to the unit from the admitting office the following three (3) items, the face sheet, addressograph plate and a Hematology requisition.

PATIENT ADMISSION

1. Place addressograph plate into holder with assigned room number on it.
2. Stamp Medication Administration Record and Patient Care Form, complete datelines and needed information on the chart forms, the M.A.R., Patient Care Form, Lab and Diagnostic procedure and Fluid Adm. Form if needed.
3. Place in the chart holder the chart forms and surgery forms if needed. The M.A.R. goes in the Kardex. Patient Care Forms, Lab and Diagnostic Procedure and Fluid Adm. goes in the Patient Care Notebook.
4. Leave the Profile Sheet on the desk top for the NA to complete the admission process.
5. Stamp and complete Hematology and Urinalysis Slips if the Physician orders UA. If the test needs to be run at a specific time or if the patient is scheduled for surgery, write this information across the tip of the requisition. (Check surgery schedule.)
6. Complete the graphic sheet chart. Obtain the vital signs, BP, and weight from the Profile Sheet.
7. Complete information and datelines on all of the above forms.
8. Label the chart using name tape (use magic marker). Put the patient's last name and the Physician's last name, write the patient's first name on a small piece of tape if the patient is scheduled for surgery.
9. Record allergy or none known (in red) on the profile M.A.R. and Physician order and flag the chart with allergy tape if needed.
10. Stamp a medicine card for chart rack. At bottom write Doctor's last name and date. Stamp a white strip for the brewer cart, to use to identify medicine drawer.
11. Transcribe Doctor's Orders.
12. Send requisitions to Pharmacy, Lab, X-ray, etc. and phone diets to dietary. All treatments, scans and other procedures are to be scheduled by phone.
13. Leave transcribed orders with requisitions in the chart (bracket the orders). Put your initials and time and leave for the nurse to check and initial.

14. Notify attending Physician(s) of patient's room number.

15. Chart admission into census book.

16. Face Sheet: Back - Consents to be signed by patient or relations and witnessed.

NOTE: Notify "Orders for New Admissions" if the patient has or has not brought orders with them at #5629.

V-TECS 45
L.A. #7

SAMPLE OF ORDERS WRITTEN AT ADMISSION

Complete bedrest.

Low Na Diet.

Routine CBC & UA.

Serum electrolytes.

ESR & SGOT.

Stat. EKG.

Digitoxin 0.2 mg. p.o. q.d.

Meperidine 75 mg. 1Mq^{4}n p.r.n. for chest pain

Secobarbital sodium gr. $\overline{\text{iss}}$ h.s. p.o p.r.n.

VS q^{2}h Call Dr. Dickson for P>120 or <60.

V-TECS 45
L.A. #9

STUDENT________________________

DATE___________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Transcribe admission orders.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When transcribing admission orders, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Inspected new admission data for doctor's orders.	( )	( )	( )	( )	( )
2. If orders were not present, notified charge nurse and New Admission for Orders office.	( )	( )	( )	( )	( )
3. Transcribed orders accurately.	( )	( )	( )	( )	( )
4. Selected all forms needed to institute the activity specified in the admission orders.	( )	( )	( )	( )	( )
5. Identified and prepared the routine diagnostic requisitions for patient.	( )	( )	( )	( )	( )
6. Presented forms to charge nurse for approval.	( )	( )	( )	( )	( )
7. Routed all forms to appropriate destination.	( )	( )	( )	( )	( )
8. Bracketed orders, placing name, title and time of completion to the left of the order sheet.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Route delayed diagnostic reports of discharged/transferred patients

---

PERFORMANCE OBJECTIVE

Confronted with a situation in which the ward clerk has received a diagnostic report for a patient who was discharged/transferred, route the report to the appropriate department. All reports will be routed to correct department. (4)

PERFORMANCE GUIDE

1. Identify the report received by searching floor records.*
2. Show report to charge nurse.
3. Notify the appropriate department that report has arrived.
4. Call physician to tell him report has been received if necessary.
5. Transmit report to the appropriate department in a sealed envelope. A record cannot be considered to have "integrity" until all entries in the record are completed and all parts of the record are attached.

* South Carolina writing team suggests the following revision of performance guide #1: Identify the report received by searching addressograph plates and/or census report.

LEARNING ACTIVITIES

1. Review the purpose and importance of diagnostic testing. (Refer to Lesson 16, V-TECS, OBJ. 51.)
2. Listen to a resource speaker from hospital personnel explain the ramification of failing to route delayed diagnostic reports.
3. Discuss established procedure for transmitting reports to appropriate departments/units. Transfer: Write transferred room number (in red) above the name plate; stamp; return to departments in sealed envelope. Discharge: Send report form to Medical Records department.
4. Illustrate in a flowchart on the board the steps involved in routing delayed diagnostic reports.
5. Role play among classmates the routing of delayed diagnostic reports of discharged/transferred patients.
6. Write individually the steps involved in routing a delayed diagnostic report. The instructor must rate the outline as "fully accomplished."

RESOURCES

hospital personnel

TOOLS AND EQUIPMENT

appropriate forms

EVALUATION

Using materials provided, the student will route one delayed diagnostic report to the appropriate department. The instructor must rate the performance as "fully accomplished."

V-TECS 52
L.A. #6

STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Route delayed diagnostic reports of discharged/transferred patients.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
When routing delayed diagnostic reports of discharged/transferred patients, the student:					
1. Identified diagnostic report.	( )	( )	( )	( )	( )
2. Notified physician for the appropriate department.	( )	( )	( )	( )	( )
3. Transmitted report to the appropriate department.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Deposit or withdraw patient's money or valuables from safe

---

PERFORMANCE OBJECTIVE

Given a patient's money or valuables, deposit and withdraw from a safe. No item will be lost and will be retrievable upon proper request. (4)

PERFORMANCE GUIDE

1. Obtain a "valuables" envelope and two acceptable witnesses. Note: Some hospitals are now employing a bonded person who is responsible for handling all valuables in which event the ward clerk's duty in relation to valuables is to notify that person of needs.
2. List and describe each item and denomination of money on the valuables envelope.
3. Secure patient's signature (or family member's) on valuables envelope.
4. Obtain signature of two witnesses of legal age and secure envelope.
5. Arrange safe transportation for items to safe and obtain receipt.
6. Record transaction on proper forms.
7. With receipt, obtain items from safe and return to patient in the same condition as they were received.
8. If family member wishes to take the valuables, make certain he/she signs for same.

LEARNING ACTIVITIES

1. Discuss the responsibilities of the ward clerk who is charged with handling "valuables" (upon admission, transfer, and/or discharge).
2. Visit a unit to observe the actual handling of "valuables" by an experienced ward clerk.
3. View an overhead transparency of a "valuables envelope"; learn what is needed in each section per established health care facility policy.
4. Role play the patient or family/ward clerk oral communication which may occur when transacting the deposit or withdrawal.
5. Explain importance of a receipt as well as any necessary signatures. Discuss ramifications of failure to secure either on part of ward clerk.
6. Practice this task in a classroom simulation.
7. Describe in writing for evaluation by the instructor the steps involved in depositing and withdrawing a patient's valuables from the safe.
8. Demonstrate mastery of the task by performing the 8 performance guides in a simulated situation. The instructor must rate the performance as "fully accomplished."

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

"valuables" envelope
"valuables"

EVALUATION

Using provided information and supplies, the student will deposit and withdraw patient's money or valuables from safe and place receipt in the front of the patient's chart. All items on the instructor's checklist must be addressed and rated "fully accomplished."

V-TECS 39
L.A. #8

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Deposit or withdraw patient's money or valuables from safe.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When depositing or withdrawing patient's money or valuables from safe, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Obtained a "valuables" envelope and listed and described each item on the envelope.	( )	( )	( )	( )	( )
2. Secured signatures of patient and two acceptable witnesses.	( )	( )	( )	( )	( )
3. Arranged safe transportation and obtained receipt.	( )	( )	( )	( )	( )
4. Recorded transaction on proper form.	( )	( )	( )	( )	( )
5. With receipt, obtained items from safe and returned to patient.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Clerically transfer patients

PERFORMANCE OBJECTIVE

Given an order regarding the transfer of a patient, perform all clerical activities relating to transfer in, out, or within unit, omitting no detail. All items on the instructor's checklist must be rated "fully accomplished." (4)

PERFORMANCE GUIDE

1. Locate the written doctor's order.
2. Notify charge nurse and transcribe the order.
3. Obtain authorization and new addressograph plate from admitting office and make certain that receiving unit is ready for patient.
4. Record information on census sheet, floor report, roster, condition sheet, TPR, and diet worksheets.
5. Notify business office, diet kitchen, switchboard, information desk, housekeeping department, physician and others as needed.
6. Prepare new bed label and arm band.
7. Change room number on medicine and treatment tickets.
8. Transfer all chart forms, including old medical records, X-rays, Kardex cards, and medications.
9. See that transfer is recorded on nurses' notes: Date, time, mode of transportation to and from.
10. Enter information into computer, if applicable.
11. See that new room number is placed on the labels of all the patient's belongings, and that all belongings are moved.

Note: South Carolina writing team suggests a revised listing. (Refer to the following revised performance guide.)

PERFORMANCE GUIDE (South Carolina version)

1. Check Physician orders for a transfer order, before transferring a patient.
2. Contact admitting and accept the new room assignment.
3. Contact the new unit to insure the room is ready.
4. Stamp the activity slip filling in the transfer block. The new unit will complete by putting in the new room number.
5. Take the chart from the chart rack, (leave dividers in), Medication Administration Record (M.A.R.) from Kardex. The Patient Care Form, the Diagnostic and Miscellaneous Procedure form from the Patient Care Notebook, clip to the back of the chart.
6. Requisition verification; send with the Patient Chart (may clip under paper clip). If results are on the chart, throw those verifications away.

7. Collect and put into a brown bag: all medications (check refrigerator), name plate, all tapes from chart, name card from chart rack, and the patient's name strip from medicine.
8. Notify the following departments: Patient Information, Dietary, Housekeeping, Lab, Mail and Flower Desk, and Pharmacy if the patient is receiving an IV Additive Medication.
9. Notify all attending physicians of new room number.
10. Chart in Census Book.
11. Complete the Housekeeping Slip.
12. Make sure the nurse has called a report of the patient's condition to the new unit and has charted the transfer note on the IDP notes.
13. Initial chart on right hand corner of face sheet to indicate the chart is up-to-date and completed.

LEARNING ACTIVITIES

1. Discuss and demonstrate method for contacting Admitting Office (i.e., give name, title, unit; patient's name; present room number; and request room assignment.)
2. Discuss method for contacting new unit (i.e., give name, title, unit; patient's name and new room assignment. Ask whether or not room is ready.)
3. Distribute activity slip (sample attached) and demonstrate the proper procedure for completing.
4. Discuss the proper procedure for preparing patient's chart and medication for transfer according to hospital policy. (Note items 5-7 of S.C. performance guide.)
5. Discuss the procedure for calling listed departments and physicians according to hospital policy (i.e., give name, title, unit; patient's name and new room assignment).
6. Demonstrate with aid of overhead transparency the method for completing census sheet (sample attached).
7. Demonstrate with aid of overhead transparency the method for completing housekeeping slip (sample attached).
8. Discuss method for relaying nurses' duties according to hospital policy.
9. Demonstrate method for initialing face sheet according to hospital policy.
10. Observe an experienced ward clerk transferring patient.
11. With the aid of an experienced ward clerk, clerically transfer a patient following the items on the attached instructor's checklist. The instructor will observe and rate. A rating of "fully accomplished" must be achieved.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

transfer order
patient's chart
appropriate forms
overhead projector & transparencies

EVALUATION

Using provided information and materials, the student will clerically transfer one patient in, out, and within the unit. No detail will be omitted. A demonstration for the instructor must warrant a rating of "fully accomplished" according to the checklist.

Stamp

PATIENT ACTIVITY

PATIENT ACTIVITY

COMPLETED BY Unit Secretary

☐ DECEASED

MONEY RECEIVED ON DISCHARGE $

DISCHARGE TAKE HOME DRUGS ☐ NO CHARGES ATTACHED ☐

TRANSFER	PATIENT NUMBER:	ROOM: 2031 BED:	TO	ROOM: 702 BED:

V - TECS 38
L.A. #6

DAILY CENSUS REPORT

FLOOR ______ CENSUS 12:00 MIDNIGHT ______ D

ADMISSIONS

NO.	TIME	NAME

DISCHARGES

NO.	TIME	NAME

RECEIVED BY TRANSFER

NO.	FROM DIV.	NAME
	Receiving Unit	

DISCHARGED BY TRANSFER

NO.	TO DIV.	NAME
Transfer	unit	

DEATHS

NO.	TIME	NAME

	MALE		FEMALE	
	Adult	Newborn	Adult	Newborn
Remaining Last Report				
Admitted				
Received Per Transfer				
Total				
Discharged				
Died				
Remaining 12:00 Midnight				

Form A1-2 4/74

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V - TECS 38
L. A. #7

BEST COPY AVAILABLE

NURSING STATION
ENVIRONMENTAL SERVICE DISMISSAL NOTICE

DATE__________ UNIT______________

Patient Room No.	Discharge Time / Actual Time Vacated	Hskp. I Received / Completed	Supervisor Checked	Time Released
1. Room	transferred to 702			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

V-TECS 38
L.A. #11

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Clerically transfer patients.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When clerically transferring patients, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Checked Physician orders for a transfer order, before transferring a patient.	( )	( )	( )	( )	( )
2. Contacted admitting and accepted the new room assignment.	( )	( )	( )	( )	( )
3. Contacted the new unit to insure the room was ready.	( )	( )	( )	( )	( )
4. Stamped the activity slip filling in the transfer block. The new unit will complete by putting in the new room number.	( )	( )	( )	( )	( )
5. Took the chart from the chart back, (left dividers in) Medication Administration Record (M.A.R.) from Kardex. The Patient Care Form, the Diagnostic and Miscellaneous Procedure Form from the Patient Care Notebook, were clipped to the back of the chart.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

BEST COPY AVAILABLE

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Clerically transfer patients.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
6. Sent requisition verification with the Patient Chart (may clip under paper clip). If results were on the chart, threw those verifications away.	( )	( )	( )	( )	( )
7. Collected and put into a brown bag; all medications (check refrigerator), name plate, all tapes from chart, name card from chart rack, and the patient's name strip from medicine.	( )	( )	( )	( )	( )
8. Notified the following departments: Patient Information, Dietary, Housekeeping, Lab, Mail and Flower Desk, and Pharmacy if the patient was receiving an IV Additive Medication.	( )	( )	( )	( )	( )
9. Notified all attending physicians of new room number.	( )	( )	( )	( )	( )
10. Charted in Census Book.	( )	( )	( )	( )	( )
11. Completed the Housekeeping Slip.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

STUDENT____________________________

DATE_______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Clerically transfer patients.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
12. Made sure the nurse has called a report of the patient's condition to the new unit and has charted the transfer note on the IDP notes.	( )	( )	( )	( )	( )
13. Initialed chart on right hand corner of face sheet to indicate the chart is up-to-date and completed.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMNG ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Clerically discharge patients

PERFORMANCE OBJECTIVE*

Given a patient to be discharged and the necessary forms, information, and equipment: perform the discharge procedures and prepare the discharge checklist without error or omission. (4)

* South Carolina writing team suggests a revised wording of the performance objective. (Refer to the following revised performance objective.)

S.C. PERFORMANCE OBJECTIVE

Given an order regarding the discharge of a patient, perform all clerical activities relating to discharge, omitting no detail. All items on the instructor's checklist must be rated "fully accomplished."

PERFORMANCE GUIDE**

1. Verify the doctor's order or have an "against medical advice" form signed.
2. Notify business office about the discharge.
3. Make follow-up appointments and give written data to the patient.
4. Notify nurse of any prescriptions or home-care instruction forms needed.
5. Check that patient has received his/her valuables and any medicine he/she brought in.
6. Call the family and arrange for transportation and escort or call an ambulance if so instructed.
7. Obtain discharge clearance form from the family and claim hospital property.
8. Obtain a wheelchair and an attendant to accompany patient to the transport vehicle.
9. See that the room is checked for any forgotten articles.
10. Arrange and check the chart for any forgotten articles.
11. Return unused medication to pharmacy.
12. Notify the housekeeping department, information desk, switchboard, diet kitchen, therapy department, admission office.
13. Remove patient's name from the posted lists and worksheets.
14. Update the floor census, condition sheet, floor reports.
15. Remove and dispose of Kardex, addressograph plate, and medication charge bar.
16. Prepare the discharge checklist -- sign it if applicable. (See sample attached.)
17. Return old charts and X-rays.

** South Carolina writing team suggests a revised listing. (Refer to the following revised performance guide.)

S.C. PERFORMANCE GUIDE

1. Be sure that all physicians have written a discharge for the patient.
2. Complete Activity Slip.
   a. **Check Discharge Block**
   b. **Check Take Home Drug Block** if applicable.
3. Send Take Home Drug Slip to Pharmacy before the patient goes to the Business Office.
4. Instruct the patient, or family, as to the location of the Business Office.
5. If the patient has to return to the doctor's office, make return appointment and give to the patient.
6. Attach verification from Activity Slip to the front of the patient's chart.
7. Complete **Housekeeping Slip:** Put (1) the patient's room number and (2) the time the patient leaves the unit.
8. Complete the chart by having all forms up-to-date (take out dividers).
   MEDICATION ADMINISTRATION RECORD - Front: Time and Date of Discharge
   Back: Check validation of nurse's initials, name and title
   Place at back of chart with the **Patient Care Form** (in Notebook).
9. Notify the following: Dietary, Patient Information, Mail and Flower, Hourekeeping, attending Physician, and Pharmacy if the patient is receiving an IV Additive Medication.
10. If you are receiving a new admission immediately, take medication from Medication drawer, put in plastic bag, and place in pharmacy basket. If not, drugs may be left in Med. drawer.
11. Chart dismissal in Census Book.
12. When all responsibilities are completed, initial the top right hand corner of the face sheet and send the chart to the Business Office.
13. Face Sheet at Top:
    Discharge date -- Present
    Discharge time -- the time the patient leaves the unit with escort to home.
    Check back of face sheet for appropriate signatures.

LEARNING ACTIVITIES

1. View transparency of a sample activity slip (attached) and discuss the ward clerk's responsibility in completing it according to hospital policy.
2. Review procedure for completing and routing Take Home Drug Slip according to hospital policy (sample attached). Emphasize the policy of giving to patient or family member to take to business office, returning verification copy.
3. Review and practice policies (i.e., informing them of Business Office location, etc.).
4. Demonstrate method for completing Appointment Card (sample attached) if patient must return to doctor's office.

5. Show procedure for correctly placing verification copy from Activity Slip according to hospital policy.
6. View transparency of housekeeping slip (sample attached) and correctly complete it as a class.
7. Study and discuss the information sheet titled "Procedure for Completing Patient's Chart."
8. Practice through role play with classmates the procedure for calling listed departments according to hospital policy -- (i.e., give name, title, unit; patient's name and room number; time of discharge).
9. Demonstrate as a class with aid of a transparency the method for completing census sheet (attached).
10. Write on board an outline describing the method for completing face sheet according to hospital policy.
11. Observe an experienced ward clerk clerically discharge a patient following the items on the attached instructor's checklist. The instructor will observe and rate. A rating of "fully accomplished" must be achieved.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

discharge order
patient's chart
appropriate forms
addressograph
overhead projector & transparencies

EVALUATION

Using the provided materials and information, the student will clerically discharge one patient, omitting no detail. All items on the instructor's checklist must be rated "fully accomplished."

Stamp

PATIENT ACTIVITY

COMPLETED BY: Unit Secretary

☐ DECEASED

MONEY RECEIVED ON DISCHARGE $

DISCHARGE	TAKE HOME DRUGS ☒	NO. CHARGES ATTACHED ☐	ROOM: 7016	BED:	TIME	HOUR: 10	MIN: 15
TRANSFER	PATIENT NUMBER:		ROOM:	BED:	TO:	ROOM:	BED:

TAKE HOME DRUGS

PHARMACY	DEPT. # 112	ITEM 10002
DATE Present	PHARMACIST To be completed	
your name / title ORDERED BY / TITLE	CHARGE Cin $ Pharmacy	

Name Plate

DRUG — PLEASE PRINT ALL INFORMATION	FORM	DOSE
℞ DARVON-N	tab	100
DIRECTIONS:	ON HAND	5
$\dot{\bar{\text{i}}}$ tab $\bar{\text{q}}$ 3-4 hrs. P.R.N. Pain	ADD	5
	TOTAL	10

_______________ M.D.
Dispense as written

_______________ M.D.
Substitution Permitted

DEA # _______________

Office Address _______________

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Appointment Card

Doctor's Name ______________________________

Office Address ______________________________

____

Date ______________________________

Time ______________________________

V - TECS 48
L. A. #6

NURSING STATION
ENVIRONMENTAL SERVICE DISMISSAL NOTICE

DATE__________ UNIT______________

Patient Room No.	Discharge Time Actual Time Vacated	Hskp. I Received Completed	Supervisor Checked	Time Released
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

PROCEDURE FOR COMPLETING PATIENT'S CHART

PATIENT'S CHART: WARD CLERKS WILL COMPLETE THE FOLLOWING BEFORE CHART LEAVES THE UNIT. PATIENT DISCHARGES AND TRANSFERS.

1. Stamp chart forms with the patient's name plate side one and two -- (addressograph).
2. **Date Line** - completed. Check on all chart forms.
3. Physician orders, transcribed.
4. **Graphic Sheet** - TPRs, B/P, weight, urine and stools, diet and intake. Complete date line using month, day and year on admission date; month and day thereafter. Hospital day/PO-PP line.
5. **Crossmatch and Blood Administration** - Blood given or released.
6. **Profile** - Information complete with RN's signature.
7. **Interdisciplinary Progress** - Nursing Discharge Summary Notes: complete #5-#6 and #8. The Nurse is also to write in the discharge summary that the patient verbalizes understanding of the discharge instructions as outlined in the care plan.
8. **Medication Administration Record** - **Front:** Time and date patient discharged.
   Time and date patient admitted.

   Back: Check validation of nurse's initials, name and title.
9. **Face Sheet** - **Back:** Check for patients signature and witness when needed.

   Front: (At top) Discharge date - present date of discharge.

   Discharge time - the time patient leaves the unit with escort home.
10. Ward Clerk to initial in top right corner, to show that the chart is complete.

V - TECS 48
L.A. #9

DAILY CENSUS REPORT

FLOOR ______________________ CENSUS 12:00 MIDNIGHT ______________________ D.

ADMISSIONS

NO.	TIME	NAME

DISCHARGES

NO.	TIME	NAME
419	3 pm	Leaving unit

RECEIVED BY TRANSFER

NO.	FROM DIV.	NAME

DISCHARGED BY TRANSFER

NO.	TO DIV.	NAME

DEATHS

NO.	TIME	NAME

	MALE		FEMALE	
	Adult	Newborn	Adult	Newborn
Remaining Last Report				
Admitted				
Received Per Transfer				
Total				
Discharged				
Died				
Remaining 12:00 Midnight				

Form A1-2 4/74

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V-TECS 48
L.A. #12

STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Clerically discharge patients.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When clerically discharging patients, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Was sure that all physicians have written a discharge for the patient.	( )	( )	( )	( )	( )
2. Completed Activity Slip.					
A. **Checked Discharge Block.**	( )	( )	( )	( )	( )
B. **Checked Take Home Drug Block** if applicable.	( )	( )	( )	( )	( )
3. Sent Take Home Drug Slip to Pharmacy before the patient went to the Business Office.	( )	( )	( )	( )	( )
4. Instructed the patient, or family, as to the location of the Business Office.	( )	( )	( )	( )	( )
5. If the patient had to return to the doctor's office, made return appointment and gave to the patient.	( )	( )	( )	( )	( )
6. Attached verification from Activity Slip to the front of the patient's chart.	( )	( )	( )	( )	( )
7. Completed **Housekeeping Slip:** Put (1) the patient's room number and (2) the time the patient left the unit.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

V-TECS 48
L.A. #12 cont'd.

STUDENT________________________

DATE___________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Clerically discharge patients.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
8. Completed the chart by having all forms up-to-date (take out dividers).	( )	( )	( )	( )	( )
MEDICATION ADMINISTRATION RECORD-Front: Time and Date of Discharge	( )	( )	( )	( )	( )
Back: Checked validation of nurse's initials, name and title	( )	( )	( )	( )	( )
Placed at back of chart with **Patient Care Form** (In Notebook).					
9. Notified the following: Dietary, Patient Information, Mail and Flower, Housekeeping, attending Physician, and Pharmacy if the patient was receiving an IV additive Medication.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Clerically discharge patients.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
10. If receiving a new admission immediately, took medication form from Medication drawer, put in plastic bag, and placed in pharmacy basket. If not, drugs may be left in Med drawer.	( )	( )	( )	( )	( )
11. Charted dismissal in Census Book.	( )	( )	( )	( )	( )
12. When all responsibilities are completed, initialed the top right hand corner of the face sheet and sent the chart to the Business Office.	( )	( )	( )	( )	( )
13. Face Sheet at Top:					
Discharge date -- Present	( )	( )	( )	( )	( )
Discharge time -- the time the patient left the unit with escort to home.	( )	( )	( )	( )	( )
Checked back of face sheet for appropriate signatures.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

V-TECS 42

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Instruct patient or family of discharge procedures

PERFORMANCE OBJECTIVE

Given an impending discharge, give instructions to a patient (or family of the patient) regarding discharge procedures, considering patient's age and state of disability. Instructions must agree with posted policy. Family must be notified promptly and participate in transportation decisions and must provide the business office clearance form before patient leaves the unit. (4)

PERFORMANCE GUIDE

1. Explain the need for the doctor's order for discharge.
2.* Explain to family how to obtain a discharge clearance form from the business office.
3. Discuss arrangements for transportation and escort.
4. Make follow-up appointment for patient and give date and time to patient in written form according to physician's instructions.
5. Give out home care instruction forms and prescriptions if any. Nursing audit criteria stress preparation for discharge. Ward clerks are expected to provide patients with necessary written or printed materials but actual patient teaching is done by nurses.
6.* Post the business office discharge clearance form in the appropriate area.

* South Carolina writing team suggests a revised wording of performance guide 2 and 6. (Refer to the following revised performance guide numbers and 6.)

S.C. PERFORMANCE GUIDE

2. Give the family a discharge clearance form from the unit.
6. Post the patient's discharge on the housekeeping slip at actual discharge time.

LEARNING ACTIVITIES

1. Review the pertinent points from the preceding lesson on clerically discharging patient. Choose those points which expand on the 6-point performance guide for this lesson.
2. Interview 3 persons who are willing to relate their hospital experience. Inquire whether or not they were adequately instructed regarding discharge procedures. If so, or if not, what were they told and how were they treated? Report to class conclusions about important points to remember.
3. Discuss the hospital's policy regarding hours for discharging patients, police cases, the payment of bills (emphasizing the referral of certain questions to proper departments or persons).

4. Discuss the instruction responsibilities of the ward clerk and the nurse at the time of discharge.
5. In a mock situation, practice instructing a patient of the discharge procedures.
6. Research and report to class the times when a family member rather than a patient would receive instruction at the time of discharge.
7. With the assistance of an experienced ward clerk, instruct a patient or family member of the discharge procedures. The instructor will observe and must ultimately rate the performance as "fully acomplished."

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms

EVALUATION

Using materials provided, the student will instruct a patient or family member of the discharge procedures. The performance must warrant a rating of "fully accomplished" by the instructor.

V-TECS 42
L.A. #7

STUDENT ____________________

DATE ____________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Instruct patient or family of discharge procedures.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When instructing patient or family of discharge procedures, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Provided instructions to the patient (or family of patient) regarding discharge procedures.	( )	( )	( )	( )	( )
2. Made follow-up appointment for patient.	( )	( )	( )	( )	( )
3. Posted the business office discharge clearance form.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Assemble and check chart for medical records on discharge

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PERFORMANCE OBJECTIVE

Given the chart of a discharged patient, assemble and route the chart for release to the medical records room. Chart must not be returned for completion or correction. (4)

PERFORMANCE GUIDE

1. Remove chart back and dividers; assemble all parts of record.
2. Check that every page has been stamped in the correct place with this patient's addressograph plate.
3. Check that all lab, X-ray, EKG, and other diagnostic reports belong to this patient. Missing or misfiled reports will cause an incomplete or erroneous medical record which could affect future medical care, medical audit studies, and statistical information. **J.C.A.H.**
4. Check that consultation forms are complete and signed.
5. Check for nurses' signatures on all shifts from date of admission.
6. Verify that all doctors' orders have been processed and signed.
7. Check to see if history, physical, and progress notes have been written and signed by doctor.
8. Verify that the time and date of discharge are on the face sheet.
9. Verify that nurses' admission and discharge notes are written and conform to established audit specifications.
10. Obtain latest medicine sheet and check for signatures.
11. Place chart forms in sequence acceptable to medical records department.
12. Check that corrections were made in a legally acceptable manner.
13. If chart is incomplete, notify concerned person to complete it at once.
14. Protect chart's confidentiality during transportation.

* South Carolina writing team suggests a revised listing. (Refer to the following revised performance guide.)

S.C. PERFORMANCE GUIDE

1. Remove chart back and dividers; assemble all parts of record.
2. Stamp chart forms with the patient's name plate and addressograph, side one and two.
3. Check all forms and make sure date lines are completed.
4. Complete graphic sheet.
5. Release all blood, if necessary.
6. Check profile sheet for completion and RN's signature.
7. Complete Medication Administration Record.
8. Complete Face Sheet.

9. Initial chart on right hand corner of face sheet to indicate the chart is up-to-date and completed.

LEARNING ACTIVITIES

1. Using the attached sample list of forms to be included in a typical discharge chart, construct a similar list applicable to the health care facility being used as a training site.
2. Discuss the break down of chart and removal of chart back.
3. Review use of patient's name plate and addressograph. Discuss and practice proper placement of imprinting.
4. Review all forms with date lines and method of completion.
5. Review procedure for completing graphic sheet.
6. Discuss Crossmatch and Blood Administration Form and procedure for completion (sample attached).
7. Research and write a summary of the procedure for completion of each form used in the health care facility training site.
8. Demonstrate method for initialing face sheet according to hosptial policy.
9. Observe an experienced ward clerk assemble and route the chart (of a discharged patient) for release to the medical records rooms.
10. Visit the medical records room to observe the process of handling the charts which are received.
11. With the aid of an experienced ward clerk, perform the task of assembling and checking the discharged patient's chart for medical records. No errors or omissions may be made. The instructor will observe and rate according to the attached instructor's checklist. A rating of "fully accomplished" must be achieved.

RESOURCES

experienced ward clerk
medical records personnel

TOOLS AND EQUIPMENT

patient's chart
appropriate forms
addressograph
pens and pencils

EVALUATION

Using material and information provided, the student will assemble and route discharged patient's chart to medical records room. No errors or omissions are allowed. A rating of "fully accomplished," based on the items in the instructor's checklist, must be achieved.

CHART DISCHARGE ORDER

1. Face Sheet
2. Patient History
3. Progress Notes
4. Operation consent
5. Postoperative record
6. Anesthesia record
7. Transfusion record
8. Surgical pathology reports
9. Clinical pathology reports
10. EKG, EEG, endoscopy reports
11. X-ray reports
12. Consultation reports
13. Physician's orders
14. Medication Administration Record
15. Graphic charts
16. Nurses' notes
17. Intake and output sheets

MEMORANDUM

TO: Nursing Unit

FROM: Blood Bank

RE: Cross Match and Blood Administration Form - additive (initialing)

The revised form has 3 new columns, **Release Date**, **Disposition**, and **Disposition Date**.

The revised form is to be used in the following manner:

A. The first six columns (**Date**, **Unit Number**, **Type**, **Rh**, **Component**, **Release Date**) will be completed by the Blood Bank when the cross match is performed.

B. The **Disposition** and **Disposition Date** columns are to be completed as follows:

1. If the blood is transfused, the NURSE records "Transfused" in the disposition column and records that date in the Disposition Date Column, and writes her/his initials in the remarks column.

2. If the blood is released, the Ward Clerk writes "Released " in the disposition column and records that date in the Disposition Date Column, and **writes her/his initials in the remarks column**.

The Blood Bank will continue to send the Blue BBI cross match slip to the floor when blood is released.

Blood Bank Personnel have begun charting the cross match and Blood Administration forms; this will hopefully eliminate the delay in charting when patients have been transferred.

Whenever possible, please, attempt to continue using the same cross match and Blood Administration form when ordering additional cross matches. At no time should there be more than 2 incomplete cross match and Blood Administration forms on a patient's chart.

ALL BLOOD WILL AUTOMATICALLY BE RELEASED THE DATE INDICATED IN THE RELEASE DATE COLUMN, UNLESS THE BLOOD BANK IS NOTIFIED.

PATIENT TYPE__________ RH FACTOR__________ INITIALS__________

DATE	UNIT #	TYPE	RH	COMPONENT	RELEASE DATE	DISPOSITION RELEASED/TRANSFUSED	DISPOSITION DATE	REMARKS

SCBHN FORM #494

CROSS MATCH AND BLOOD ADMINISTRATION

V - TECS 35
L. A. #6

REQUESTED BY ORDERED BY M D

SPECIMEN:

EXAMINATION REQUESTED:

DEPT.	CODE	TEST
X X	X X	
X X	X X	
X X	X X	
X X	X X	
X X	X X	
X X	X X	
X X	X X	

DATE | TIME ☐ A M. ☐ P M | COLLECTED BY

LABORATORY MISCELLANEOUS	DATE	PATHOLOGISTS:	TECH	CHARGE

CALLED TO TIME ☐ A M ☐ P M DATE BY

LABORATORY MISCELLANEOUS

PATIENT'S CHART VERIFICATION COPY

LABORATORY BLOOD BANK 1

Date Collected Time Collected Tech

Routine ☐
Stat ☐ Date ________

Ordered by
M D ________

Nurse ________
Date and Time of Intended Transfusions

Pathologists

☐ Whole Blood or Packed Cells may be used ☐ Yes ☐ No
☐ Whole Blood Unit
☐ Packed Cells
☐ Platelet Concentrate
☐ Fresh Frozen Plasma
☐ Albumin
☐ Plasma Protein Fraction
☐ Cryoprecipitate
☐ Leukocyte-Poor Red B-Cells
☐ Other

Donor #	Donor Group and Rh
is Compatible with Recipient named	Recipient Group and Rh
Expiration Date	Tech
[illegible]	Date

REMARKS

PRETRANSFUSION CHECK
[illegible]

RESULTS OF TRANSFUSION
[illegible]

BLOOD BANK
CHART COPY
VERIFICATION COPY

BEST COPY AVAILABLE

V-TECS 35
L.A. #11

STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Assemble and check chart for medical records on discharge.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When assembling and checking chart for medical records on discharge, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Assembled and checked all parts for the chart.	( )	( )	( )	( )	( )
2. Completed selected forms as necessary (i.e., graphic sheet, profile sheet, medicine sheet).	( )	( )	( )	( )	( )
3. Routed patient's chart to medical records room.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Prepare credit slip for return of unused medication

PERFORMANCE OBJECTIVE

Given the equipment, supplies, and unused medications for three patients, prepare a drug credit slip for each patient and return the drugs to the pharmacy. All drugs must be listed, count must be exact, and medication must be transported by authorized personnel. (4)

PERFORMANCE GUIDE

1. Verify discontinuation of drug.
2. Obtain pharmacy credit slip and drug envelope.
3. Stamp pharmacy credit slip with correct patient's name.
4. List name, strength, and form of drug on credit slip in proper location.
5. Count number of tablets, capsules, ampules, etc. of each drug. Caution: NEVER, NEVER touch the drug product, and do NOT remove it from ITS container.
6. Enter amount of each drug in quantity column.
7. Enclose drugs and credit slip in the drug envelope.
8. Make certain medication is transported safely in an authorized manner.

LEARNING ACTIVITIES

1. Discuss procedure for reviewing Physicians' Order form for discontinuance of drug.
2. Discuss procedure for discontinuing drug on Medication Administration Record; review attached sample policy.
3. Distribute pharmacy credit slip and demonstrate procedure for completing (sample attached).
4. Demonstrate proper procedure for placing drugs and credit slip into drug envelope according to hospital policy.
5. Discuss procedure for transporting according to hospital policy.
6. Research the general responsibilities of the physician, the pharmacist, and the nurse in medication therapy for patients. Summarize in writing.
7. Research the kinds of information the ward clerk needs to know about medications; include the responsibilities. Summarize in writing.
8. Visit the pharmacy and observe the process employed when unused medications are returned.
9. Report to the class the reason the ward clerk must never touch the medication. Write on the board and leave for several days.
10. Observe an experienced ward clerk return drugs to the pharmacy.

11. With the aid of an experienced ward clerk prepare credit slips for return of the unused medications of three patients. The instructor will observe. A rating of "fully accomplished" is expected based on complete listing of drugs, exact count, and the correct transportation.

RESOURCES

pharmaceutical personnel
experienced ward clerk

TOOLS AND EQUIPMENT

pharmacy credit slip
Medication Administration Record
physician's order form

EVALUATION

Using the information and materials provided, the student will prepare credit slips for return of the unused medications of three patients. Performance must warrant a "fully accomplished" rating by the instructor.

MEDICATION ADMINISTRATION RECORD (MAR)

DEFINITION AND PURPOSE

The Medication Administration Record (MAR) provides a legal record of medication administration.

POLICY

1. Initiate a Medication Administration Record (MAR) for each patient on admission.

    a. Enter continued, single and pre-operative orders on the front of the form in appropriate sections.
    b. Enter PRN orders on the back of the form with exception of sleep medications and laxative PRNs which are recorded on the front of the form.
2. Use black ink for hours between 7:00 a.m. and 6:59 p.m., use red ink for hours between 7:00 p.m. and 6:59 a.m. Record 7 a.m. in black ink, 7 p.m. in red ink.
3. Use the following hours for administering medications unless the doctor orders specific hours.

    Daily . . . . 9 a.m. (usually)

    q.i.d. . . . . 9 a.m. - 1 p.m. - 5 p.m. - 9 p.m.

    t.i.d. . . . . 9 a.m. - 1 p.m. - 5 p.m.

    b.i.d. . . . . 9 a.m. - 9 p.m. or 9 a.m. - 5 p.m.

    $q^{4}h$ . . . . 1 a.m. - 5 a.m. - 9 a.m. - 1 p.m. - 5 p.m. - 9 p.m.

    $q^{6}h$ . . . . 4 a.m. - 10 a.m. - 4 p.m. - 10 p.m.

    $q^{8}h$ . . . . . . 5 a.m. - 1 p.m. - 9 p.m. or 1 a.m. - 9 a.m. - 5 p.m.

    $q^{12}h$ . . . . 9 a.m. - 9 p.m.

    The following medication hours apply to Pediatrics:

    b.i.d. . . . . 9 a.m. - 8 p.m.

    q.i.d. . . . . 9 a.m. - 1 p.m. - 5 p.m. - 8 p.m.

    $q^{6}h$ . . . . 4 a.m. - 10 a.m. - 4 p.m. - 10 p.m. or

    6 a.m. - 12 N - 6 p.m. - 12 MN

The following medication hours apply to Orthopedics:

Daily . . . . 8 a.m.

b.i.d. and q^{12}h . . . 8 a.m. - 9 p.m.

t.i.d. . . . . 8 a.m. - 12 N - 5 p.m.

q.i.d. . . . . 8 a.m. - 12 N - 5 p.m. - 9 p.m.

q^{4}h . . . . 4 a.m. - 8 a.m. - 12 N - 4 p.m. - 8 p.m. - 12 MN

The following medication hours apply to Psychiatric:

Daily . . . . 8 a.m.

b.i.d. . . . . 8 a.m. - 4 p.m. or 8 a.m. - 8 p.m.

t.i.d. . . . . 8 a.m. - 12 N - 4 p.m.

q.i.d. . . . . 8 a.m. - 12 N - 4 p.m. - 8 p.m.

q^{4}h . . . . 4 a.m. - 8 a.m. 12 N - 4 p.m. - 8 p.m. - 12 MN

q^{6}h . . . . 6 a.m. - 12 N - 6 p.m. - 12 MN

q^{8}h . . . . 8 a.m. - 4 p.m. - 12 MN

q^{12}h . . . . 8 a.m. - 8 p.m.

4. Account for all squares by initialing, "x"ing out, or entering red asterisks (*) or circling surgery or X-ray in red.
5. Enter expiration dates in pencil. The expiration date is three days (72 hours) or seven days (168 hours) on all controlled drugs depending on drug classification.
6. Validate all initials on MAR by signing full name and title on back of form.
7. Record allergies in red and surgery and diagnosis in black ink at top right section of the MAR.
8. Do not discontinue medication when the patient goes to surgery.
9. Discontinue postoperatively those medications not reordered.
10. Complete bottom section of MAR (doctor, age, name and date and time of admission and discharge).

RESPONSIBLE PERSONS

RN, LPN
Unit Secretary - Transcribe order, complete date line, fill in top and bottom headings on MAR.

GENERAL INSTRUCTIONS

1. Do not repeat charting in Interdisciplinary Progress Notes. Document results of PRN medication in IDP notes. It is not necessary to include dosage or route of administration.
2. Do not record treatments on Medication Administration Record.
3. Place a large number in pencil in the box on the top right of the MAR to indicate how many forms are in current use.
4. When a patient goes to surgery and medications are continued postoperatively write in red above transcription of medication orders POST-OP and the surgery date. If a dose or doses were not given while the patient was in surgery, do the following when patient returns to unit from recovery room; write "surg" in red and circle it in red in the time slots missed. Under the last entry in the single orders section write POST-UP and date in red when a patient goes to surgery. If medications are not renewed postoperatively, discontinue medications in usual manner.
5. Use medicine card to flag Kardex when pre-op, single order drugs are to be given. Write in center of card "S.O." or "Pre-Op" and along edges write dates and times medication is due.
6. When any part of the medication order is changed (i.e.: time, dose, route, etc.) discontinue the present order and rewrite the entire order in appropriate place. Do not cross through the present order and write in the new order (i.e.: IM, IV)
7. If patient goes to surgery multiple times during one hospitalization, write in red ink "and," the type of surgery and the date after the first post-op date on the MAR.
8. If an antibiotic is ordered qid check with the physician to see if he wants the medication given around the clock.

PROCEDURE

1. Chart Continued Medications (**medications given on regular basis**) as follows:
   a. Enter on front top section of MAR.
   b. Enter expiration date when applicable in pencil.
   c. Transcribe by entering order date, initials of person transcribing order, and medication, dosage, frequency, route of administration in column specified.
   d. List hours medication is to be given vertically under HR column. Use a new line for each hour, beginning with the first hour listed under policy.
   e. Draw a heavy line across the page after the last hour is entered. Leave one vacant space and draw another line.
   f. Complete "Dates Given" line horizontally beginning with first date a continued medication order is written.
   g. "X" out all squares preceding the first dose of medication administred.
   h. "X" out squares under the dates medication is **NOT TO BE GIVEN** when a medication is to be given every other day; given one day, left off two, etc.
   i. Number the appropriate squares when medication is to be given for a specific number of doses. Place a penciled "X" in the two

columns following the last dose due. Bracket and write in pencil "STOP" with time and date. Nurse giving the last dose "STOPS" the medication in the usual manner.

- j. Initial the square corresponding to the **Correct Date and Correct Time** after the medication is given.
- k. Enter the actual time the medication is given and initials of person administering in the appropriate square(s) when a medication is given at a time different from ordered time.
- l. Document omitted drugs as follows:
  1. if patient is in X-ray and misses tid, quid, q^4h, or q^6h medications enter "X-ray" and circle it in red in the block where your initials would have gone.
  2. if a patient is in surgery (see General Instructions 4).
  3. if a patient misses a medication for any other reason place a red asterisk (*) in the appropriate square(s). A corresponding red asterisk (*) is made on the IDP notes along with reason medication was omitted.
- m. Divide block into half diagonally if the medication is being administered by injection. Place code for injection site in top half of block and initials in bottom half of block.
- n. Discontinue medications by drawing one red line through the complete medication order and down the hour(s) in the Hours Column. "X" out the remaining square(s) for that day, and the next full days squares. Bracket the "X"ed out square(s) and print the word STOP, your initials and the date after the bracket.
- o. Enter PRN sedatives and PRN in red ink. When laxative or sedative PRNs are given enter the time given and initials in appropriate space; "X" out the square on the date a dose is omitted.

2. Chart **Single Orders and Pre-Operative Medications** as follows:
   - a. Transcribe by entering order date, initials of person transcribing order.
   - b. Enter medication order as written.
   - c. Enter date and time medication was given or is to be given under TO BE GIVEN column.
   - d. Initial NURSE column **after** giving medication.
   - e. Use medication card to flag Kardex when single order and pre-op medications are due.
3. Chart **PRN Medications** as follows:
   - a. Enter on back of form in PRN Medications section.
   - b. Transcribe order by entering order date, expiration date (in pencil), initials, and order including medication, dosage, frequency, and route of administration.
   - c. Write PRN and reason for giving in red.
   - d. Chart that medication was given by entering vertically, the date, the time, initials and injection site if applicable beside the appropriate medication when each dose is given.
   - e. Transcribe each PRN order on a new set of three lines.
   - f. Discontinue PRN medications by drawing a single red line through the entire order, "X"ing out two (2) columns, bracket in the time, write STOP, the date, and your initials. Refer to MAR accompanying this procedure for examples.

g. Document dose given in square when a range of medication is ordered along with time of administration. Divide dose and time with a line.

V - TECS 43
L.A, #2

All Entries Must Be Printed

Medication Administration Record

Enter Here IN PENCIL Number of Forms in Use: I

Name
Case No.
Room No.

Diagnosis D.U.B
Surgery 11-1-79 VAGINAL Hysterectomy AND 11/2/79 Resuturing VAGINAL CUF
Allergie Test (Record in Red) Codeine

DATES GIVEN

Form No. 3

OR Date Initials	Exp. Date Time	Medication—Dosage—Rt. of Adm.	HR.	10/31	11/1	11/2	11/3	11/4	11/5	11/6	11/7	11/8	11/9	11/10	11/11	11/12
10/31		KeFLex . 500mg - P.O	9													
		q.i.d	1													
			5	JC												
			9	J.C												
11/1 J.T		KeFLIN gm's ÷ I.V.	4													
		Piggyback - q̄ 6 hrs	10								D/c p̄ 10 A.M. Dose					
		x 8 doses	4								11/6/83					
			10													
11/2 J.T		Dalmane - 30mg P.O	Nurse													
			Time													
11/2 J.T		Sliding Scale A.C and	7³⁰				SP									
		Give Regular Insulin SQ.	Dose				0									
		according to blood Sugar levels	11³⁰			SP	SP									
		As Follows	Dose			[illegible]	[illegible]									
		400 - 500 mg% - 20 units SQ	4³⁰			J.t	J.t									
		300 - 400 mg% - 15 units SQ	Dose			[illegible]	[illegible]									
		200 - 300 mg% - 10 units SQ	9													
		100 - 200 mg - no														
11/3		Valium - 10mg . P.O	9	J.t	J.T				Stop		11/3		M. [illegible]		2/	
		q̄ B.I.D.	9	J.t	J.T											

(Use Pencil)

(Use Red Ink)

SINGLE ORDERS – PRE-OPERATIVES

Enter here in pencil No. of Forms in use

OR Date Initials	Medication—Dosage—Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial	OR Date Initials	Medication—Dosage—Frequency—Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial
10/31 J.C	Pre-op Dalmane . 30mgm P.O	10/31			11/2 J.C	Pre-op Date Demerol . 50mg			
	Demerol . 50mg					Vistaril . 50mg } 2m	11/2		
	Vistaril - 50mg } 2m	11/1	8³⁰	J.C		atropine . 0.4mg			
	atropine . 0.4mgm					Post. OP. Date			
	Post. OP. Date ← (Use Red Ink)								

(PRN ORDERS – SEE REVERSE SIDE)

Doctor KNOW Intern Date/Time Admitted 10-31-82 - 3³⁰ P.M.
Age 35 Religion Baptist Date/Time Discharged
Name Smith Nancy

BEST COPY AVAILABLE

V - TECS 43
L. A. #3

Stamp
c̄ name plate

PHARMACY

DATE____________________

CREDIT

NOT MORE THAN THREE ITEMS PER SLIP USE BALLPOINT PEN ONLY TO COMPLETE FORM

ITEM(S)	DOSAGE	I.V.	I.M.	TAB.	CAP	OTHER	QNT.
[illegible]	10 mgm		✓				3
Amcill	500 mg				✓		10

DEPT. #	ITEM	CHARGE	ORDERED BY	TITLE.
112	10002	$	Unit Secretary Name / title	

BEST COPY AVAILABLE

V-TECS 43
L.A. #11

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare credit slip for return of unused medication.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing credit slip for return of unused medication, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Prepared a drug credit slip for a patient.	( )	( )	( )	( )	( )
2. Enclosed drugs and credit slip in the drug envelope.	( )	( )	( )	( )	( )
3. Transported medication safely in an authorized manner.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Perform clerical discharge procedure for deceased patient

---

PERFORMANCE OBJECTIVE

Given access to supplies, policies, and information concerning a death, perform the clerical discharge procedure for deceased person and complete the discharge check list. All required forms will be obtained and prepared without error; and all required departments notified. (4)

PERFORMANCE GUIDE

1. Determine that pronouncement has been correctly charted.
2. Obtain a death certificate for physician to sign.
3. Obtain autopsy consent form for physician if required. Note: Not required for a medical examiner's case.
4. Obtain and imprint three mortuary tags.
5. List and route all of deceased person's belongings following established safeguarding policies. Note: Signature of receptor and witnesses of great importance.
6. Notify all concerned departments and persons, including mortician if so directed.
7. Requisition the shroud pack.
8. Minimize commotion on unit.
9. Complete all other discharge activities in the regular manner.

* South Carolina writing team suggests a revised listing. (Refer to the following revised performance guide.)

S.C. PERFORMANCE GUIDE

1. Determine that pronouncement has been correctly charted.
2. Contact the hospital chaplain by phone or page.
3. Stamp the activity slip.
4. Complete all other discharge activities in the regular manner.
5. Prepare forms that others are responsible for completing.
6. Obtain autopsy forms, if necessary.

LEARNING ACTIVITIES

1. Read aloud and discuss the attached information sheet titled "Patient Death Procedure." (Emphasize that the ward clerk must check the progress notes signed by the physician to make certain death pronouncement is made.)
2. Listen to a resource speaker (the chaplain) explain his/her role in the event of death.
3. Discuss the procedure for contacting the chaplain's office (i.e., give name, title, unit and patient's name, if after working hours, ask operator to page the chaplain who is "on call").

4. Distribute activity slip and discuss procedure for completing, allowing time for individual practice (sample attached).
5. Distribute the attached sample forms and discuss hospital personnel responsibilities for completing them: "Authorization for Releasing Body to Undertaker," "Consent for Autopsy," "Burial - Removal - Transmit Permits." (Include death certificate, if pertinent.)
6. Visit a unit to discuss where the forms are kept, how to obtain according to hospital policy, and where to route them once they are completed.
7. Discuss clerical procedure to be followed in preparation for an autopsy, if requested. Review the "Patient Death Procedure" studied during learning activity #1.
8. Write personal attitude about death; then consider through small group discussion whether or not this special attitude might affect the quality of work as a ward clerk.
9. Outline on the board the postmortem procedure, addressing the questions on the attached sheet by that title.
10. Role play the kinds of questions the ward clerk might be asked by the deceased patient's family.
11. Observe a postmortem procedure to understand fully what care of a patient after death means.
12. Observe the procedures related to hospital records following a patient's death.
13. Under the supervision of an experienced ward clerk, perform the clerical discharge procedure which is followed in the event of a death. The performance must warrant a rating of "fully accomplished" by the instructor.

RESOURCES

chaplain
experienced ward clerk

TOOLS AND EQUIPMENT

patient chart
appropriate forms
addressograph
nameplate
pens and pencils

EVALUATION

Using provided information and materials, the student will perform the clerical discharge procedure which is followed in the event of a death. Performance must warrant a "fully accomplished" rating by the instructor.

PATIENT DEATH PROCEDURE

1. Contact the Hospital Chaplain by phone or page.

2. Stamp the patient activity slip.

3. Put the time of death on slip. This will be the time patient is pronounced dead by the physician on the pink progress sheet.

4. Send completed activity slip to Business Office immediately.

5. Send chart to Medical Records immediately upon completion.

6. The Unit Manager or Administrator will get the "consent for autopsy" form completed.

7. The Chaplain will be responsible for completing the "release the body to the undertaker" form.

If an autopsy is to be performed, send the completed chart, the burial removal transit permit, the consent for autopsy (3) and authorization to release body to the undertaker form to the morgue with the body.

Send with the body to the morgue the following:

Autopsy

1. Completed chart
2. (3) Consent for autopsy
3. Burial Transit Permit
4. Release the body to Funeral Home

NOTE: 1. The Burial Transit Permit

The Unit Manager (A.M.'s), Evening Administrator (P.M.'s), Unit Secretary (night's) may pick up from the switchboard and notify the night supervisor (nursing) of the patient's death.

2. The above is in addition to a normal discharge procedure.

3. Notify Emergency Room of patient's room and unit number as they will be able to direct the undertaker to the correct unit.

ISOLATION: In the event of death of the isolation patient, remind the nurse to complete the Reminder to the Funeral Home Form and attach to the death certificate. (See next page.)

UNIT SECRETARIAL AIDS FOR INFECTION CONTROL

1. Definition of Nosocomial Infection:

   An infection that develops within a hospital or is produced by microorganisms acquired during hospitalization.

2. Signs and Sumptoms of a Nosocomial Infection

   a) A sudden elevation in the temperature of a hospitalized patient.
   b) A new antibiotic and/or culture and sensitivity order 48 to 72 hours after admission.
   c) Nurses reporting infection.
   d) Documentation of a nosocomial infection on the face sheet during hospitalization and at discharge.

3. How to Report:

   Stamp addressograph of patient on paper and place in folder.

4. The Isolated Patient

   a) Place the isolation sticker on the front of the chart and have the nurse confirm the type of isolation.

ISOLATION

   b) In the event of death of the isolation patient, remind the nurse to complete the following form and attach it to the death certificate.

NOTICE: To Funeral Home Directors

HANDLE WITH PRECAUTIONS!

This patient has been on Isolation Procedures while a patient

at ____________________ Hospital.

The patient had probable ____________________________.

V - TECS 44
L. A. #4

PATIENT ACTIVITY

COMPLETED BY: Unit Secretary name / title

☒ DECEASED

MONEY RECEIVED ON DISCHARGE $

Stamp
c̄
Name plate

DISCHARGE	TAKE HOME DRUGS ☐	NO. CHARGES ATTACHED ☐	ROOM	BED	Pronounced TIME	
					HOUR	MIN

TRANSFER	PATIENT NUMBER	ROOM	BED	TO: ROOM	BED

V-TECS 44
L.A. #5

AUTHORIZATION FOR RELEASING
BODY TO UNDERTAKER

DATE________________________

TIME________________________ a.m.
p.m.

This is to authorize the above-named hospital to release the body of

__________________________________who died about_______________a.m.

about___________________(time)_____p.m.___(date)______, to the under-taker____.

Witness__________________________

Signed________________________
(Nearest Relative)

____
Nurse in charge

____
(Relationship)

Remains Received in Good Condition

Signed___________________________
(Mortician)

For______________________________
(Name of Funeral Home)

Body Released by_________________

Date_____________________________

Hour_____________________________a.m.
p.m.

V-TECS 44
L.A. #5

CONSENT FOR AUTOPSY

A. I (we) request and authorize the physicians and surgeons in attendance at ________________________________ Hospital to perform a complete autopsy on the remains of ________________________________, and I (we) authorize the removal and retention or use for diagnostic, scientific, or therapeutic purposes of such organs, tissues, and parts as such physicians and surgeons deem proper and to dispose of the same as they may deem proper.

This authority is granted subject to the following restrictions:

____

____

Students may be permitted to observe.

Dated this _____ day of ____________________, 19__ at Columbia, South Carolina.

Sign here if spouse:

________________________________ (Witness)

________________________________ (Signed)

________________________________ (Witness)

Relationship:

________________________________ (Witness)

B. If not a wife or husband of the deceased, please complete the following: I (we) assume custody of the body for burial purposes and assume responsibility for payment of burial expenses. My relationship to the deceased is ________________. (If not related, state, "none.") I consent to the statement in Section A.

Dated this ____ day of ______________, 19__ at Columbia, South Carolina.

Witnesses:

______________________ ______________________

Signature

____

A. FORM: **BURIAL-REMOVAL TRANSIT PERMITS**

Burial-removal transit permits are sequentially numbered by D.H.E.C. and must be accounted for closely. These permits will be stored in the Medical Records Department and released to the units as deaths occur. These forms may be secured through the Unit Managers and Evening Administrators during the hours which they cover and will be kept at the switchboard during the 11-7 shift and at all time on weekends. All personnel who obtain burial transit forms must log the appropriate information on the sheet accompanying the forms, specifying the patient and the unit where they will be used.

If you have any questions regarding these changes, please direct them to the director of medical records.

In the event of death:

1. The form is completed by a Nurse, Unit Manager, Administrative Representative, Unit Secretary.
2. Using one set (copies with carbons), write in the patient's name, date (month, day, year) the name of the funeral home and address. Use only Columbia in the city.
3. Check Removal under method of Disposal.
4. Write in the name and address of the patient's physician.
5. Write date of death, as Date of Issue.
6. The name of our sub-registrar will be incluuded; however, the person completing the certificate will initial (his/her own initials) following the name of the director of medical records.
7. The last two rows of information will be completed by the Health Department.
8. The funeral home representative will sign the back of the pink sheet. (Please remove carbon copy before signing back).
9. The white copy is given with the body, to the funeral home representative.
10. The pink and yellow copies are securely placed with the patient's chart.
11. The director of medical records will send all pink copies to the Health Department.

12. Emergency Room will deliver the pink copy to Medical Records within 48 hours, and the yellow copy will stay with the Emergency Room Record.
13. If, for any reason, the original Burial Transit form is not used, void the set and return it to Medical Records.

V - TECS 44
L.A. #5

BURIAL – REMOVAL – TRANSIT PERMIT

DEPT. OF HEALTH and ENV. CONTROL
DIVISION OF VITAL RECORDS

111988
Permit No.

40-04
County

Name of Deceased: Patients Full Name

Date of Death: Present

Time of Death: Pronounced by the Physician

Fetal Death (Ck one): Yes ( ) No ( )

Place of Death (Hospital or Street and Number): Baptist Medical Center at Columbia

City or Town: Columbia South Carolina

Attending Physician, Medical Examiner, or Coroner: Physicians Full Name from the Chart.

Address: Physician office address

Autopsy (check one): Yes ( ) No ( )

A certificate of death having been filed, or the requirements of the laws of this state having been complied with, permission is hereby granted to dispose of this body.

Date Issued: Undertaker to complete

Funeral Home, Name and Address: Dunbar Funeral Home or the Funeral Home who picks up the body.

Method of Disposal: ( ) Burial ( ) Cremation (✓) Removal ( ) Other — always

Signature of Registrar or other authorized individual: [illegible] Kelley RRA

Name and Address of Cemetery or Crematory: Undertaker & address

Date of Disposition: Undertaker to complete Date

Signature of Sexton or Person in Charge: Undertaker

DHEC - 676-150M - 10-74

THIS COPY TO BE GIVEN TO FUNERAL DIRECTOR

BEST COPY AVAILABLE

V-TECS 44
L.A. #9

POSTMORTEM PROCEDURE

1. What is required before a death can be certified?
2. What is an autopsy? Who must give written permission for an autopsy to be performed?
3. What is a coroner's case?
4. What is a shroud and how is it used?
5. Following postmortem care, where in the hospital is the body stored? Why?

V-TECS 44
L.A. #13

STUDENT ____________________

DATE ____________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Perform clerical discharge procedure for deceased patient.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When performing clerical discharge procedure for deceased patient, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Obtained and completed all forms concerning a death.	( )	( )	( )	( )	( )
2. Notified all concerned departments and persons.	( )	( )	( )	( )	( )
3. Completed all other discharge activities as appropriate.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES

TASK: Prepare a replacement patient identification band

PERFORMANCE OBJECTIVE

Given a patient for whom a replacement identification band is needed, his/her addressograph plate, and an ID band with its insert, prepare a new ID band. Required data will be clearly visible, patient and ID band will match. (4)

PERFORMANCE GUIDE

1. Correctly identify the patient by asking the patient to give his/her name or by having an authority figure identify the patient. Caution: This step is vitally important.
2. Select the correct addressograph plate for this patient.
3. Locate an ID band and an ID insert strip.
4. Stamp identification insert with addressograph or type patient information on it.
5. Place the insert in the band making certain the required data is visible: Name, hospital number, physician, etc.
6. If the ward clerk has the responsibility of applying the band to the wrist or ankle of the patient, make certain that secured band will permit the insertion of one finger betweeen band and patient's skin.

LEARNING ACTIVITIES

1. Study independently why identification plates are important to hospital personnel.
2. Invite resource speaker (RN) to suggest some situations in which identification bracelets might be extremely important.
3. Take a tour through the admitting office to discover the procedures required for all routine admission, including the preparation of identification bracelets.
4. Display the identification bracelet and discuss where they are prepared and how they are put on the patient.
5. Practice in groups of two the putting on of the bracelet.
6. Practice individually the preparation of the insert.
7. Discuss the extreme importance of matching patient with band. Role play in front of class how this identification should be made.
8. Perform the task for the instructor and verbally explain throughout the performance. A rating of "fully accomplished" must be achieved.

RESOURCES

registered nurse

TOOLS AND EQUIPMENT

addressograph
ID band and insert strip

EVALUATION

Using, materials and information provided, the student will prepare a replacement identification band. Required data will be clearly visible; patient and ID band will match; instructor must rate the performance as "fully accomplished."

V-TECS 46
L.A. #8

STUDENT____________________________

DATE____________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare a replacement patient identification band.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing a replacement patient identification band, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Prepared a replacement identification band.	( )	( )	( )	( )	( )
2. Correctly identified the patient.	( )	( )	( )	( )	( )
3. Applied the band to the wrist or ankle of the patient in the correct manner.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Obtain signatures on consent, against advice, or release forms

---

PERFORMANCE OBJECTIVE

Given a directive to have a specific patient sign a release to allow the side rails to be down when established policy dictates that they should be up, select and execute the release form. Form prepared must contain the signature of the patient and two acceptable witnesses and be photocopyable. (4)

PERFORMANCE GUIDE

1. Obtain the specified form indicated.
2. Fill in required information.
3. Take the form and a pen to patient, with two legal-aged witnesses.
4. Read the form to the patient*, making certain that is understood. Legal requirements use the term "informed consent," and consents signed by patients who are not of legal age, or are sedated or irrational are not valid. This judgment should be made by the nurse or doctor. Legal interests of both patient and agency will be protected when release form is signed and incorporated into chart.
5. Have the patient sign the form in front of two witnesses.
6. Have witnesses sign and date the form. Note: Ward clerk students are not employees of the institution and should not serve as witnesses.
7. Place form in patient's chart.

* South Carolina writing team suggests that the beginning of performance guide #4 be revised to read: Have the patient read the form; or if patient is unable to read, then read ...

LEARNING ACTIVITIES

1. Discuss the legal ramifications if signatures are not obtained or the type of form is not appropriate. Listen to a resource speaker (preferably a lawyer) with background in this area.
2. List on the board any responsibilities which the ward clerk has in regard to obtaining signatures on forms. Also include the responsibilities of the nursing staff.
3. Investigate the policy of the local health care facility. Outline the procedures to be followed by the ward clerk.
4. Observe an experienced ward clerk and/or nurse as a patient's signature is obtained. (Include securing the signatures of witnesses.)
5. Investigate the different types of forms requiring a signature (sample attached).
6. Role play a situation in which a signature must be obtained on a release form.

7. Perform the task as the instructor observes. A rating of "fully accomplished" must be achieved.

RESOURCES

lawyer
experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms
pens

EVALUATION

Using provided directions and forms, the student will obtain a patient's signature on a release form. The patient's signature plus that of two acceptable witnesses must appear. The instructor must rate the performance as "fully accomplished."

V-TECS 66
L.A. #5

CONSENT TO OPERATION, ANESTHETIC AND OTHER MEDICAL SERVICES

Date ______________________

Time ______________________ a.m.
p.m.

1. I authorize the performance upon ______________________
(myself or name of patient)
of the following operation ______________________
(statenature and extentof operation)

to be performed under the direction of Dr. ______________________ and/or such assistants as may be selected by him to perform such operation.

2. I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures or services than those set forth above and I further authorize and request that the above-named surgeon and/or his associates, partners, assistants or designees perform such procedures as are, in his professional judgment, necessary and desirable.

3. I consent to the administration of such anesthetics as may be considered necessary or advisable by the person responsible for such service.

4. I consent to the disposal by hospital authorities of any tissue or members which may be removed during the course of the operation.

5. The nature, purpose and possible consequences of the operation, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me by my attending physician and/or surgeon. No guarantees or assurances have been made or given by anyone as to the results that may be obtained.

6. I, THE UNDERSIGNED, HAVE HAD THIS FORM EXPLAINED TO ME AND FULLY UNDERSTAND THE CONTENTS OF THIS AUTHORIZATION.

Signed ______________________
(patient or authorized person)

Witness ______________________

____
(relationship)

V-TECS 66
L.A. #5

AUTHORIZATION FOR USE OF DRUGS AND/OR PROCEDURES FOR INVESTIGATIONAL PURPOSES

DATE______________________

TIME______________________a.m.
p.m.

I hereby voluntarily consent for ______________________________
(myself or name of patient)
participation in the following investigation ______________________________
______________________________, the nature and purposes drug and/or
(type procedure and/or name of drug)
procedure and the pertinent potential complications, if known, have been explained to me by Dr. ______________________.

I acknowledge that while no guarantee or assurance has been made as to the result that may be obtained, since investigational results cannot be fully foreseen, it is understood that every precaution consistent with the best medical practice will be taken and I do herreby release the above-named physician, hospital and its personnel from any and all responsibility for injuries which may result from my voluntary participation.

WITNESS______________________ SIGNED______________________

WITNESS______________________

WITNESS______________________

WITNESS______________________

I hereby certify that I have explained to ______________________, patient, the experimental nature of the administration of the procedure or drug set out above, together with the uncertainties as to the results and possible harmful effects.

SIGNED______________________M.D.
(Physician)

V-TECS 66
L.A. #5

REQUEST FOR STERILIZATION

Date___________ Time__________ A.M. / P.M.

We, the undersigned husband and wife, each being of sound mind, request Dr.______________________________ and assistants of his choice, to perform upon ____________________________ the following operation:________________

____

(State name and extent of operation).

It has been explained to us that this operation is intended to result in sterility although this result has not been guaranteed. We understand that a sterile person is NOT capable of becoming a parent.

____
Husband

____
Wife

____
Witness

V-TECS 66
L.A. #5

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

DATE ____________________________

Permission is hereby given the authorities of the ______________________ Hospital, ______________ (City), ______________ (State) to give to

Name ____

Street ____

City ____

or representative, any and all information in respect to any sickness or injury, including the nature of such physical illness or injury, medical history, consultations, prescriptions, x-rays, copies of hospital or other medical records or charges for service with respect to any illness or injury.

The injury or illness for which this authorization is granted are those resulting from an accident, injury or hospitalization to

Name ____

Address ____

Dates of Admissions ____________________________

WITNESS

____

____

SIGNED ______________________________
(Patient or Authorized Person)

____
Relationship

CONSENT TO RADIATION THERAPY

DATE______________________________

TIME______________________________

I authorize Dr.________________________ or others at this Hospital as he may designate to administer ______________________________ therapy to ________ ________________________ and to continue such treatment from time to time as he may deem advisable. The effect and nature of this treatment, possible alternative methods of treatment, and the risks of injury despite precaution have been explained to me. I know that radiation is potent in destroying tissue. No guarantee or assurance has been given by anyone as to the results that may be obtained.

SIGNED____________________________

WITNESS___________________________

V-TECS 66
L.A. #5

RELEASE FROM RESPONSIBILITY FOR DISCHARGE

DATE______________________________

TIME______________________________

This is to certify that I, ____,
a patient in the above-named hospital, am being discharged against the advice of the attending physician and of the hospital administration. I acknowledge that I have been informed of the risks involved and hereby release the attending physician, his associates, partners, assistants, or designees, and the hospital and any of its personnel from all responsibility for any ill effects which may result from such discharge.

WITNESS_______________________ SIGNED_______________________
(Patient or Authorized Person)

WITNESS_______________________ _______________________
(Relationship)

V - TECS 66
L.A. #5

RELEASE FROM RESPONSIBILITY FOR TRANSFER

DATE________________________________

TIME________________________________ A.M.
P.M.

This is to certify that I, ____, a patient in the above-named hospital, am being transferred to ____________________ ________________________________ at my own request. I acknowledge that I have been informed of the risks involved and hereby release the attending physician, his associates, partners, assistants or designees, the hospital and any of its personnel from responsibility for any ill effects which may result from such transfer.

WITNESS____ SIGNED____________________
(Patient or Authorized Pers

WITNESS____

____
Relationship

V-TECS 66
L.A. #7

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Obtain signatures on consent, against advice, or release forms.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When obtaining signatures on consent, against advice, or release forms, the student:	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Prepared a consent form.	( )	( )	( )	( )	( )
2. Secured the signature of the patient and two legal-aged witnesses.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Prepare and maintain TPR and diet worksheet

PERFORMANCE OBJECTIVE

Given access to the appropriate materials and information, prepare and maintain the diet worksheet for one day and the TPR worksheet for one day. Worksheets must be complete, legible, and reflect patient population, needs and condition changes in accordance with source data. (4)

PERFORMANCE GUIDE

1. Select appropriate worksheet and fill in headings. Note: Chemically treated carbon sets are often used for the patient roster, condition sheets, TPR and diet worksheets ...{or diet order requisition}...
2. Place the name and room number of each patient on the worksheet, making certain that duplicates are legible. ...{If room is empty, still write the room number on the sheet.}...
3. Place the correct diet for each patient in diet column.
4. Note ...{in red}... all diet changes or holds in column provided.
5. TPR worksheet is prepared in same manner.
6. Add new admissions ...{name and room number}... to worksheets.
7. Delete names discharged, transfers - out, or deaths from worksheets.
8. Chart all information from worksheets to graphic sheets ...{and dietary diet order requisition}...

LEARNING ACTIVITIES

1. Distribute appropriate forms to students: dietary diet order requisition, 24-hr. record of patients temperatures (sample attached), and explain procedure for completing each form.
2. Review terminology associated with diet (as might be found on physician's order).
3. Research and report the reasons for closely monitoring vital signs.
4. Practice in small groups completing the diet order requisition and the 24-hr. record of patient's temperatures (distributed during learnig activity #1). Use fictional information provided by instructor.
5. Visit unit to discover where name and room numbers will be found (e.g., in name plate rack).
6. Explain where diet order is obtained (e.g., Physician's Orders and Patient Care Form).
7. Explain procedure for adding new names to list as they are admitted.
8. Explain procedure for deleting names according to hosptial policy.
9. Practice charting the temperature, pulse, and respiration readings from the attached table on the sample form provided. Record also the blood pressure reading.

10. With the supervision of an experienced ward clerk prepare diet and TPR worksheets for one day. The results must warrant a rating of "fully accomplished" by the instructor.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms
red and black pens

EVALUATION

Using materials and information provided, the student will prepare and maintain the TPR and diet worksheets for one day. The sheets must be complete, legible, and accurately reflect the source data. The instructor must assign a rating of "fully accomplished."

DIETARY DIET ORDER REQUISITION

CARBON NOT REQUIRED

BY: Unit Secretary R.N.

FLOOR: Your Unit #

DATE: Present.

V - TECS 70
L.A. #1

A.M.: 4:30
CALL TIME – D&S
9:30 A.M. & 12:30 P.M.

ROOM NO	NAME	HOLD. ECT.	FULL (REGULAR)	SOFT	LIQUIDS		SPECIAL DIETS	DINNER CHECK	SUPPER CHECK
					SURG.	FULL			
		N.P.O.							

BEST COPY AVAILABLE

Reynolds+Reynolds CELINA, OHIO LITHO IN U.S.A.

V - TECS 70
L.A. #1

TWENTY-FOUR HOUR RECORD OF PATIENTS TEMPERATURES

(Weight and Elimination)

ROOM	NAME	WEIGHT	B/P	8 AM	12 NOON	4 PM	U	S	8 PM	12 MN	4 AM
[illegible] #s	[illegible]										

FORM N4(1)-10 5/74
R 7/81

V-TECS 70
L.A. #9

TABLE OF VITAL SIGNS

DATE	TIME	TEMPERATURE	PULSE	RESPIRATION	B/P
10/6	8 a.m.	98.6	62	16	134/84
	4 p.m.	98	64	16	
10/7	8 a.m.	97.6	72	18	122/80
	4 a.m.	100	80	18	126/86
	8 p.m.	102.8	104	24	140/90
	12 mn	101.4	92	22	
10/8	8 a.m.	99.2	84	20	118/72
	12 noon	99.8	88	20	
	4 p.m.	100.6	92	20	128/76
	8 p.m.	98.2	68	18	
10/9	8 a.m.	97.8	72	16	132/70
	4 p.m.	98.4	80	16	120/80

V - TECS 70
L.A. #9

GRAPHIC/INTAKE – OUTPUT RECORD

(ADDRESSOGRAPH)

DATE															
HOSP. DAY/PO-PP															
HOUR		A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
		12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8
CHART PULSE IN RED	CHART TEMPERATURE IN BLUE														
140	105														
130	104														
120	103														
110	102														
100	101														
90	100														
80	99														
	Normal														
70	98														
60	97														
50	96														
RESPIRATIONS															
BP	S														
	D														
Weight Urine Stools															
B'Fast Lunch Dinner															
Other Dietary Intake															

DATE		INTAKE			OUTPUT			
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

DATE		INTAKE			OUTPUT			
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

DATE		INTAKE			OUTPUT			
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

FORM N4(2)-218-79)

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V-TECS 70
L.A. #10

STUDENT ______________________________

DATE ______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare and maintain TPR and diet worksheet.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing and maintaining TPR and diet worksheet, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Prepared a TPR worksheet.	( )	( )	( )	( )	( )
2. Prepared a diet worksheet.	( )	( )	( )	( )	( )
3. Charted all information from worksheets to graphic sheets.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Prepare pharmacy requisitions

PERFORMANCE OBJECTIVE

Given six doctors' orders for six medications and access to required information, requisition forms and addressograph materials, prepare the pharmacy requisitions. Requisitions must be legible, and reflect only those drugs ordered by the physician. (4)

PERFORMANCE GUIDE

1. Interpret the order.
2. Select the correct requisition forms.
3. Select the correct addressograph plate.
4. Imprint the requisition form with the plate or ...
5. Print patient's name, doctor's name, room number, and hospital number, making certain that all duplicates are legible.
6. Print name of drug, amount of dose, mode of administration, date and time ordered. CAUTION: All medications are more or less potentially lethal. It is imperative that drug requisitions be absolutely accurate. National Formulary may be consulted if indicated.
7. Have charge nurse initial the requisition.*
10. Enter transcription of order into computer if applicable.*

* South Carolina writing team suggests revised wording of performance guides 9 & 10. Refer to the following revised performance guide.

S.C. PERFORMANCE GUIDE

9. File verification copy from requisition in drawer in medicine cart until medication arrives on unit; then discard.
10. Enter transcription of order onto Medication Administration Record or into computer if applicable.

LEARNING ACTIVITIES

1. Distribute physician's order and identify medication orders (sample attached).
2. Distribute pharmacy requisition (sample attached) and explain procedure for completing, using transparency to allow for full class instruction.
3. Practice imprinting requisition with patient's name plate.
4. Research and compile in writing a table citing the common terms and abbreviations found on medication orders. Memorize.
5. Distribute and review Medication Administration Record and practice recording medication on it according to policy (or practice entering transcription into computer, if applicable.)

6. Orally recite the responsibilities of the ward clerk in medication therapy (i.e., the clerical tasks after the physician has written the order for medications).
7. Discuss importance of routing requisitions promptly.
8. Observe an experienced ward clerk on a unit prepare a pharmacy requisition.
9. With the supervision of an experienced ward clerk, prepare six pharmacy requisitions. The instructor will observe and rate the performance. A "fully accomplished" rating must be achieved.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

pharmacy requisition
physician's order
appropriate forms
patient name plate

EVALUATION

Using materials provided, the student will prepare pharmacy requisitions for six drug orders. The requisitions must be legible and 100% accurate. A rating of "fully accomplished" by the instructor must be achieved.

V - TECS 72
L.A. #1

PHYSICIAN'S ORDERS

AUTOMATIC STOP ORDER: SCHEDULE OF STOP DATES REPRODUCED BELOW IS IN TERMS OF DAYS FOLLOWING DATE OF ORIGINAL ORDER. IF STOP DATE FALLS ON SUNDAY OR HOLIDAY ORDER EXTENDED ONE DAY. TIME 11:00 A.M.

THIS ORDER DOES NOT APPLY WHEN PHYSICIAN'S ORDER INDICATES EXACT NUMBER OF DOSES AND/OR DAYS TO BE ADMINISTERED.

ANTIBIOTICS 7
SCHEDULE III MEDICATIONS 7
SCHEDULE II MEDICATIONS 3

DO NOT WRITE IN THIS SECTION IF RED ↑

(1)

(✓) START → HERE | DATE | TIME A.M. P.M. | ALLERGIES: (Use Red Ink)

1- Amcill 500 mgm TAB
Q.I.D X 5 day then D/C

2. Torecan 10 mgm
Q 3-4 hrs PRN — Nausea

(ADDRESSOGRAPH)

Stamp

_______________ M.D. DISPENSE AS WRITTEN
_______________ M.D. SUBSTITUTION PERMITTED

DO NOT WRITE IN THIS SECTION IF RED ↑

(2)

(✓) START → HERE | DATE | TIME A.M. P.M. | ALLERGIES: (Use Red Ink)

(ADDRESSOGRAPH)

Stamp

_______________ M.D. DISPENSE AS WRITTEN
_______________ M.D. SUBSTITUTION PERMITTED

DO NOT WRITE IN THIS SECTION IF RED ↑

(3)

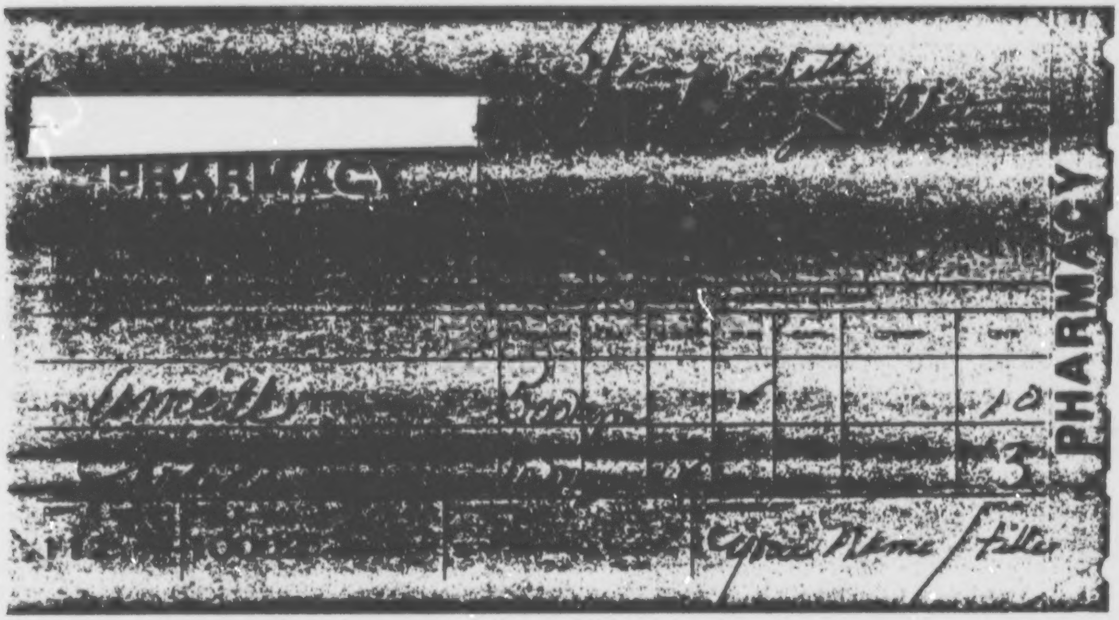
(✓) START → HERE | DATE | TIME A.M. P.M. | ALLERGIES: (Use Red Ink)

(ADDRESSOGRAPH)

Stamp

_______________ M.D. DISPENSE AS WRITTEN
_______________ M.D. SUBSTITUTION PERMITTED

BEST COPY AVAILABLE



[redacted]

PHARMACY

10

3

Agent Name / Filler

PHARMACY

BEST COPY AVAILABLE

V - TECS 72
L.A. #5

All Entries Must Be Printed

Medication Administration Record

Name

Case No.

Room No.

Diagnosis Face Sheet - From admitting

Enter Here IN PENCIL Number of Forms in Use 1

Surgery From the Anesthesia Sheet and the date of

Allergic Test (Record in Red) (Use Red Ink)

DATES GIVEN

Form No. 3

Ord Date Initials	Est. Date Time	Medication—Dosage—Rt. of Adm.	HR.	1/12	1/13	1/14	1/15	1/16	1/17	1/18	1/19	1/20	1/21	1/22	1/23	1/24
~~1/11~~		Amcill - 500 mg. - tabs	9													
~~JC~~		q.i.d X 5 days then - D/c	1									D/c - date				
			5									Ward Clerk - [illegible]				
			9											ē title.		

SINGLE ORDERS – PRE-OPERATIVES

Enter here in pencil No. of Forms in use

Ord Date Initials	Medication — Dosage — Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial	Ord Date Initials	Medication — Dosage — Frequency — Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial

(PRN ORDERS – SEE REVERSE SIDE)

Doctor KNOW Intern Date/Time Admitted 1/11/82 - 3^{30} P.m.

Age 35 Religion BAPtist Date/Time Discharged

Name Smith, NANCY

BEST COPY AVAILABLE

SIGNATURE	TITLE	SIGNATURE	TITLE

PRN Medications

Nurse giving a PRN medication enters, next to the medication, vertically, the date – time given and initials for each dose given.

Or Date Initials	& Date Time	Medication — Dosage — Frequency — Rt. of Adm.	DOSES GIVEN
1/12	17	Torecan – 10 mg. q 3-4 hrs 0 P.Rn. - PAIN	

BEST COPY AVAILABLE

V-TECS 72
L.A. #9

STUDENT__________________________

DATE__________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare pharmacy requisitions.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing pharmacy requisitions, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Interpreted the physician's order and prepared pharmacy requisition.	( )	( )	( )	( )	( )
2. Secured charge nurse's initials.	( )	( )	( )	( )	( )
3. Routed requisition form to pharmacy and processed the floor copy.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Prepare and route X-ray requisitions

PERFORMANCE OBJECTIVE

Confronted with a physician's order for a G.B. series on Mr. John Doe, Room 432, and having access to needed forms, information and equipment, prepare and route the requisition form without error or omission of any detail. Forms must supply all required information, and duplicates must be legible. (4)

PERFORMANCE GUIDE

1. Translate and interpret the order; copy it onto the Kardex.
2. Determine when this X-ray may be scheduled, depending upon this patient's preceding X-rays, consulting charge nurse if needed.
3. Select the correct requisition form.
4. Select the correct addressograph plate and imprint the requisition form.
5. Fill in all needed information making certain that you give the correct mode of transportation and that all duplicates are legible.
6. If order is STAT, notify X-ray by telephone and seek instructions from the charge nurse.
7. Locate all preparation orders associated with this X-ray in the Ward Clerk or X-ray Manual.
8. Write the preparation orders on the Kardex and requisition the supplies.
9. Notify the dietary department of the necessary diet changes.
10. Have charge nurse initial the requisition.
11. Route the requisition in the manner provided.
12. File the floor copy of the requisition.
13. Enter information into computer if applicable.

LEARNING ACTIVITIES

1. Research and write a report on the methods used in radiology.
2. Discuss the most common types of X-rays ordered (i.e., the chest, the bony parts of the body, the gastrointestinal tract, the gall bladder, and the kidneys). Emphasize that X-rays of the bones, which are the easiest to obtain , often require that the doctor specify position. Learn the positions (and abbreviations) for the positions most frequently requested {i.e., A-P(anterior-posterior); lat(lateral); obl(oblique angle); P-A(posterior-anterior)}
3. Tour the radiology department of the local health care facility; observe and learn about the equipment and meet the staff with whom the ward clerk works.
4. Visit a unit of the local health care facility to discover where the radiologist's observations are posted.

5. Listen to an experienced ward clerk serving as a resource speaker explain the responsibilities of the ward clerk in preparing and routing X-ray requisitions. Allow time for questions and answers. Distribute sample requisitions.
6. With the supervision of the ward clerk (learning act. #5) practice preparing an X-ray requisition. Orally recite routing procedures.
7. Perform for the instructor the task of preparing and routing an X-ray requisition for a gall bladder series. A rating of "fully accomplished" must be achieved.

RESOURCES

radiology department personnel
experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms
addressograph plate

EVALUATION

Using information, forms, and equipment provided, the student will requisition a gall bladder series of X-rays for Mr. John Doe, Room 432. No error or omission is allowed. The forms must contain all required information and the duplicates must be legible. A rating of "fully accomplished" by the instructor must be achieved.

X-Ray Dept.

Diagnostic Radiology	DEPARTMENT NUMBER 114	Date Exam to be Done:
Year of previous x-ray:	X-ray Number:	☐ walk ☐ Wheelchair ☐ stretcher ☐ portable

Requesting Physician:

Written By:

☐ In Patient ☐ Out Patient ☐ Emergency Room

Exam(s) Requested: (File all exams for one day on one request)

Clinical History:

Do Not Mark Below This Line (x-ray dept. use only)

ABDOMEN (FLAT & UPRIGHT)		CYSTOGRAM		HIP		NECK FOR SOFT TISSUE		T-TUBE CHOLANGIOGRAM	
ABDOMEN (FLAT)		ELBOW		HIPS (BOTH)		PARANASAL SINUSES		THORACIC SPINE	
ANKLE		ESOPHAGUS		IMAGE INTENSIFIER		PELVIMETRY		TOMOGRAMS	
CERVICAL SPINE WITH OBLIQUES		FACIAL BONES		IVP		PORTABLES		UPPER G.I.	
CHEST (PA & LATERAL)		FEMUR		IVP (HYPERTENSIVE)		POLYTOMES		UPPER G.I. & SMALL BOWEL	
CHEST FOR RIBS		FOOT		KNEE		RETROGRADE PYELOGRAM		WRIST	
CHEST (PA)		FOREARM		LOWER LEG		SELLA TURCICA		XEROGRAMS	
COLON (BA ENEMA)		GALLBLADDER		LUMBAR SPINE		SHOULDER			
COLON WITH AIR CONTRAST		GALLBLADDER (REPEAT)		LUMBAR SPINE WITH OBLIQUES		SKULL			
COMPLETE SPINE		HAND		NASAL BONES		SMALL BOWEL			

FORM #815 02

Contrast Media ____

Control Number ____

Time of Injection ____

Tech. ____

CIT-59-4 NP-10322

DEPARTMENT

271

BEST COPY AVAILABLE

V - TECS 74
L. A. #6

V-TECS 74
L.A. #7

STUDENT______________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare and route X-ray requisitions.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing and routing X-ray requisitions, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Translated and interpreted the physician's order.	( )	( )	( )	( )	( )
2. Selected and prepared a requisition for a G.B. series.	( )	( )	( )	( )	( )
3. Prepared other X-ray requisitions as directed by instructor.	( )	( )	( )	( )	( )
4. Notified dietary department of the necessary diet change(s).	( )	( )	( )	( )	( )
5. Routed and/or filed the requisition in the routine manner.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Prepare and route special therapy requisitions

PERFORMANCE OBJECTIVE

Given an order for special therapy (liver ...{brain}... scan, etc.) and the necessary forms, information, and material, prepare and route the requisitions. Forms must be complete, duplicates must be legible, and must result in the patient receiving the therapy ordered. (4)

PERFORMANCE GUIDE

1. Interpret the order, locate any associated routine orders in the Ward Clerk Manual or Procedure Book; transcribe to Kardex.
2. Make appointment if needed.
3. Select the correct requisition form(s). Note: Includes radiation therapy, nuclear medicine, hyperbaric oxygen, encephalograms, arteriograms, angiograms, etc.
4. Select the correct addressograph plate.
5. Imprint the requisition form(s).
6. Fill in all pertinent information on the requisition form(s) paying particular attention to the mode of transportation this patient requires and the drugs administered.
7. Have nurse initial the form.
8. Route the requisition form in the routine manner.
9. File the floor copy of the requisition(s).
10. Enter transcription of order into computer if applicable ...{or onto Diagnostic and Miscellaneous Procedures Form (attached)}... .

LEARNING ACTIVITIES

1. Distribute copy of physician's orders and explain how order would be written.
2. Explain procedure for calling appropriate department for appointment and discuss which orders require appointments.
3. Role play calling for appointments.
4. Distribute attached sample requisitions and related forms and discuss/practice performance guides 4-6.
5. Discuss procedure for routing form according to hospital policy (e.g., use pneumatic tube system).
6. Demonstrate placing the verification copy in back of patient's chart.
7. Discuss procedure for entering information into computer or onto the sample diagnostic & miscellaneous procedures form (attached).
8. Diagram the steps involved in the preparation and routing of special therapy requisitions.
9. Identify references offering help in spelling, descriptions, etc., of drugs (e.g., **Physician's Desk Reference**).

10. Research and prepare a table citing commonly used terms and abbreviations (including a brief description) associated with special therapy.
11. Visit a unit to observe an experienced ward clerk prepare and route an order for special therapy (preferably a liver scan).
12. Under the supervision of an experienced ward clerk, prepare and route a special therapy requisition for a brain scan. The instructor will observe and rate the performance.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms & requisitions
physician's order
patient's name plate
pen
telephone
addressograph

EVALUATION

Using materials provided, the student will prepare and route special therapy requisitions for a brain scan. The form must be complete and the duplicates must be legible. Accuracy must be 100%. A "fully accomplished" rating by the instructor must be achieved.

V - TECS 73
L. A. #3

EKG-EEG REQUEST

1-12 83 | 1.12.83 | Dr A Lee

Date Ordered | Date To Be Done | Ordered By

☒ Routine ☐ Pre OP ☐ Stat ☐ Other

Stamp

DEPARTMENT 124

QTY	Test		QTY	Test		QTY	Code	Test	Amount
X	3000	Electrocardiograph		3015	Pediatric Echo			Miscellaneous	
	3011	Treadmill		3017	Portable Echo				
	3002	Rhythm Strip EKG							
	3004	Mini Exercise		3500	Electroencephalogram				
	3016	Mayday		3501	Portable EEG				
	3012	EKG Interpretation Fee			Holter Monitor:				
	3007	Elective Cardioversion		3008	0-8 Hours				
				3009	9-16 Hours				
	3013	Echocardiogram		3010	17-24 Hours				

FILE COPY
EKG-EEG REQUEST

BEST COPY AVAILABLE

V - TECS 73
L. A. #4

EKG-EEG REQUEST

Date Ordered	Date To Be Done	Ordered By
1-12-83	1-13-83	Dr. A. Roe

☒ Routine ☐ Pre OP ☐ Stat ☐ Other

Phone to schedule
Stamps

DEPARTMENT 124

QTY	Test	QTY	Test	QTY	Code	Test	Amount
	3000 Electrocardiograph		3015 Pediatric Echo			Miscellaneous	
	3011 Treadmill		3017 Portable Echo				
	3002 Rhythm Strip EKG						
	3004 Mini Exercise	X	3500 Electroencephalogram				
	3016 Mayday		3501 Portable EEG				
	3012 EKG Interpretation Fee		Holter Monitor:				
	3007 Elective Cardioversion		3008 0-8 Hours				
			3009 9-16 Hours				
	3013 Echocardiogram		3010 17-24 Hours				

FILE COPY
EKG-EEG REQUEST

V - TECS 73
L. A. #4

NUCIFAR MEDICINE

2-80

Stamp

DEPARTMENT OF NUCLEAR MEDICINE		ORDERED BY: Dr A. Kal							
BRAIN SCAN	X	BLOOD VOLUME RBC MASS		DEPARTMENT NUMBER 117					
GALLIUM		RBC SURVIVAL							
LIVER/SPLEEN		THYROID BATTERY T-3, T-4, ETR							
LUNG-PERFUSION		T-3 ONLY		RAST (ALLERGY)		ULTRA SOUND ONLY			
LIVER-LUNG		T-4 ONLY				PREGNANCY ENTIRE 1 & 2		EYE SCAN	
LUNG-VENTILATION		* SCHILLING'S TEST				(1) FETAL AGE BI-PAR DIAM.		CARDIAC SCAN	
CARDIAC SCAN		* SCHILLING'S TEST INT. FAC.				(2) PLACENTAL LOCALIZATION		PERICARDIAL EFFUSION	
* RENAL BATTERY SCAN & RENOGRAM		* DIGOXIN ASSAY				UNUSUAL PREGNANCY		LIVER SCAN ULTRASOUND	
* PANCREAS SCAN		* GASTRIN ASSAY				PELVIC MASS		AORTA SCAN	
BONE SCAN		AUSTRALIAN ANTIGEN						MIDLINE BRAIN	
* THYROID UPTAKE & SCAN		* PLASMA RENIN ANGIOTENSIN		OTHER:				DEPT. NO.	CODE
ABDOMINAL SCAN		IGE							

* REQUIRES SPECIAL CONSIDERATIONS - REFER TO MANUAL

DEPARTMENT COPY

BEST COPY AVAILABLE

V - TECS 73
L. A. #4

MISCELLANEOUS CHARGES

1-10-83
DATE

Dr. A Roe
AUTHORIZED SIGNATURE

Unit #
DEPARTMENT

Stamps

ITEM OR DESCRIPTION	QTY.	DEPT.	CODE	AMOUNT
		MISCELLANEOUS CHARGES	TOTAL	

FILE COPY

BEST COPY AVAILABLE

X-Ray Dept.

Diagnostic Radiology

DEPARTMENT NUMBER 114

Date Exam to be Done: 1-12-82

Year of previous x-ray:

X-ray Number:

☐ walk ☐ wheelchair

☒ stretcher ☐ portable

Stamp
Phone to schedule

Requesting Physician: A. Roe

Written By: Unit Secretary Name Title

☒ In Patient ☐ Out Patient ☐ Emergency Room

Exam(s) Requested: (File all exams for one day on one request)

Arteriogram or angiograms

Clinical History: Admitting Diagnosis or a specific — Written by Physician on the Doctor order sheet.

DEPARTMENT

Do Not Mark Below This Line (x-ray dept. use only)

ABDOMEN (FLAT & UPRIGHT)		CYSTOGRAM		HIP		PARANASAL SINUSES		TOMOGRAMS	
ABDOMEN (FLAT)		ELBOW		HIPS (BOTH)		PELVIMETRY		UPPER G.I.	
ANKLE		ESOPHAGUS		IVP		PORTABLES		UPPER G.I. & SMALL BOWEL	
CERVICAL SPINE WITH OBLIQUES		FACIAL BONES		IVP (HYPERTENSIVE)		RETROGRADE PYELOGRAM		WRIST	
CHEST (PA & LATERAL)		FEMUR		KNEE		SELLA TURCICA		XEROGRAMS	
CHEST FOR RIBS		FOOT		LOWER LEG		SHOULDER			
CHEST (PA)		FOREARM		LUMBAR SPINE		SKULL			
COLON (BA. ENEMA)		GALLBLADDER		LUMBAR SPINE WITH OBLIQUES		SMALL BOWEL			
COLON WITH AIR CONTRAST		GALLBLADDER (REPEAT)		NASAL BONES		T-TUBE CHOLANGIOGRAM			
COMPLETE SPINE		HAND		NECK FOR SOFT TISSUE		THORACIC SPINE			

Contrast Media
Control Number
Time of Injection
Tech.

CIT-89-4 NP-10322

V - TECS 73
L. A. #4

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L.A. #4

Stamps

(CHECK ONE)

☐ AMBULATORY

☐ STRETCHER

☑ WHEELCHAIR

☐ BEDSIDE

Date Requisition Filed 1-10-83

Date Scan To Be Done 1-11-83

Requested by Dr. A Roe

Type of Scan

Brain Scan

PATIENT TO BE DISCHARGED TODAY ☐

FILE ONE (1) REQUISITION FOR EACH SCAN

ORDERED BY Unit Secretary R.N.

Falk -

PERTINENT CLINICAL HISTORY

Admitting Diagnosis from Face Sheet in Chart

RADIOGRAPHIC REPORT

BEST COPY AVAILABLE

FILM NO.

1-CHART COPY

SIGNATURE OF RADIOLOGIST

FORM NO. 117-01

Reynolds+Reynolds DAYTON OHIO PRINTED IN U.S.A.

V - TECS 73
L.A. #4
S-lamp

Electrocardiographic Record

ECG ORDERED BY__________________M.D.

Previous ECG Yes No	Age	Sex	Race	Hgt.	Wgt.	B.P.	Serial No.	Position	Date
	61	m	w	6'	172	140/90			

Emergency ☐
Routine ☑
Bedside ☐
Ambulant ☐

COMPUTER DATA (circle 1 in each category)

CLINICAL HISTORY (C)
0 Unknown
1 Diagnosed myocardial infarction
2 Possible ischemia/infarction
3 Pulmonary disease
4 Chronic or recent hypertension
5 Predominant mitral stenosis
6 Aortic stenosis/aortic or mitral regurgitation
7 Congenital heart disease
8 Pericarditis
9 No pertinent clinical history (routine or presurgical ECG)

or admitting
Diagnosis from the
Patient Face Sheet in
Chart

DRUGS (D)
0 Unknown
1 None of the following
2 Digitalis + antihypertensives
3 Digitalis
4 Quinidine + antihypertensives
5 Quinidine
6 Antihypertensives
7 Diuretics (not antihypertensives)

Check: Medication
Administration
Record
or ask Nurse

INTERPRETATION:

CASE#__________

V - TECS 73
L.A. #4

Schedule by Phone

Stamp

C.T. AND ULTRASOUND DEPARTMENTS

(CHECK ONE)

☐ AMBULATORY

☐ [illegible]

☑ WHEELCHAIR

☐ BEDSIDE

Date Requisition Filed 1-10-83

Date Scan To Be Done 1-11-83

Requested by Dr. J. Roe

Type of Scan Cat Scan of Head.

PATIENT TO BE DISCHARGED TODAY ☐

FILE ONE (1) REQUISITION FOR ALL SCANS THAT ARE TO BE DONE ON THE SAME DAY.

ORDERED BY

R.N.

Unit Secretary

PERTINENT CLINICAL HISTORY

Admitting Diagnosis from the Patients Face Sheet

SCAN REPORT

BEST COPY AVAILABLE

FILM NO.

Reynolds+Reynolds CELINA OHIO LITHO IN U.S.A.

CHART COPY

SIGNATURE OF RADIOLOGIST

FORM NO. 117-11

5-lamp.

Electro-encephalographic Report

NAME: ______________________ AGE: ________ DEPT: __________ DATE: __________

PURPOSE OF EXAMINATION: (include positive Neurological findings and salient features of Clinical history)

Admitting Diagnosis from the Patient Face Sheet

PREVIOUS MEDICATION: (include all sedatives and anti-convulsive drugs administered 48 hours prior to E.E.G. Examination)

Check - Medication Administration Record

E.E.G. FINDINGS:

INTERPRETATION:

E.E.G. REPORT NO.

BEST COPY AVAILABLE

V - TECS 73
L.A. #7
Stanings

(DIAGNOSTIC & MISCELLANEOUS PROCEDURES FORM)

(ADDRESSOGRAPH)

DATE	RN LPN	LAB, EKG, EEG	DATE	NURSE	DATE	RN LPN	X-RAY	DATE	NURSE
	2/3	EEG (4)	1/11	ws	1/1	2/3	Arteriogram Scheduled		
1	2/3	EKG (4)	1/11						

DATE	RN LPN	DAILY LAB, X-RAY, ETC	DATE	NURSE	DATE	RN LPN	PHYSICAL THERAPY	DATE	NURSE

DATE	RN LPN	NUCLEAR MEDICINE/ RADIATION THERAPY	DATE	NURSE	DATE	RN LPN	RESPIRATORY THERAPY	DATE	NURSE
1/	2/3	Brain Scan	1/11	[illegible]					
[illegible]		Cat Scan of head	1/11						

8/80

BEST COPY AVAILABLE

V-TECS 73
L.A. #12

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare and route special therapy requisitions.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing and routing special therapy requisitions, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Selected and prepared special therapy requisitions.	( )	( )	( )	( )	( )
2. Secured nurse's initials.	( )	( )	( )	( )	( )
3. Routed and/or filed the requisition in the routine manner.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Obtain X-rays

PERFORMANCE OBJECTIVE

Given required materials and a request for X-ray films with identifying data, obtain required X-rays. Films accepted must be those requested and must not be available to unauthorized persons. (4)

PERFORMANCE GUIDE

1. Acknowledge the request, if verbal, and record on Kardex.
2. Interpret and transcribe the order to the patient's Kardex, if written.
3. Call X-ray department and relay request if urgent.
4. Write a memorandum, giving patient's name, room number, hospital number, physician's name, and approximate date of film requested.
5. Send the memorandum to X-ray department.
6. Arrange for picking up films when X-ray department has them ready.
7. Store films safely for physician ...{and place note on top of chart as to the location}... .
8. Protect confidentiality of films.

LEARNING ACTIVITIES

1. Using a transparency, discuss how the physician's order would be written.
2. Discuss transcription procedure according to hospital policy.
3. Role play calling message to X-ray department.
4. Write (and critique fellow classmate) a memorandum requesting film. Verbally outline how it would be sent to the X-ray department.
5. Discuss that transportation must be arranged (e.g., transportation department).
6. Listen to resource speaker from X-ray department discuss the need to protect confidentiality of films.
7. Discuss the reason films must be safely stored.
8. Using the eight-point performance guide as a basis, simulate in small groups the obtaining of X-ray films.
9. Under the supervision of an experienced ward clerk, perform the task of obtaining X-ray films. The instructor will observe. The performance must warrant a "fully accomplished" rating.

RESOURCES

X-ray personnel
experienced ward clerk

TOOLS AND EQUIPMENT

- X-rays
- physician's order
- memorandum (i.e., suitable paper)
- overhead projector and transparencies

EVALUATION

Using the X-ray requests and materials provided, the student will obtain X-ray films. The films accepted must be those requested. A rating of "fully accomplished" must be achieved, based on the instructor's observations.

V-TECS 67
L.A. #9

STUDENT__________________________

DATE_____________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Obtain X-rays.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

	Student Performance				
When obtaining X-rays, the student:	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Interpreted and transcribed order to the patient's Kardex.	( )	( )	( )	( )	( )
2. Contacted X-ray department and arranged for picking up films.	( )	( )	( )	( )	( )
3. Stored films in safe manner.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Arrange escort and transportation services for therapy elsewhere

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PERFORMANCE OBJECTIVE

Given access to all required information, equipment, and a described situation, make arrangements for escort and transportation for one patient to receive therapy elsewhere. Arrangements made must satisfy legal requirements, and be compatible with patient's needs as judged by the instructor. (4)

PERFORMANCE GUIDE

1. Interpret the order.
2. Verify the time of appointment.
3. Determine that ambulance transportation will be available at time needed if applicable.
4. Determine the availability of a responsible (family member) escort at the time needed.*
5. Determine that the patient will be ready to be taken to therapy on time.*
6. Verify that the proper forms are signed, if any.
7. Record arrangements made on patient's Kardex ...{or patient care form}...
8. Prepare charge forms.

* South Carolina writing team suggests that performance guides 4 and 5 are apt to be responsibilities of the nursing staff.

LEARNING ACTIVITIES

1. Viewing a transparency of a physician's order, discuss how to verify transporting of patient elsewhere for treatment.
2. Discuss procedure for calling other facility to verify necessary information (i.e., date, time, etc.).
3. Discuss procedure for calling ambulance service and/or make necessary arrangements (e.g., date, time, facility).
4. Role play (two classmates at a time) the placing of the necessary calls.
5. Practice stamping appropriate form(s) and affixing to chart (sample attached).
6. Discuss purpose of the various required forms (sample attached).
7. Discuss the necessary information to be placed on patient care form (i.e., time of departure, facility, etc.) (sample attached).
8. Discuss with students the method to prepare charge form. (e.g., Contact Unit Manager; he/she will get charge forms from Purchasing.)
9. Under the supervision of an experienced ward clerk, perform the task of arranging escort and transportation for therapy. A rating of "fully accomplished" must be achieved, based on the instructor's observations.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

physician's order
appropriate forms
overhead projector and transparencies

EVALUATION

Using the provided information and materials, the student will arrange escort and transportation for therapy elsewhere for one patient. The arrangements must satisfy legal requirements. A rating of "fully accomplished" must be achieved, based on the instructor's observations.

RELEASE OF RESPONSIBILITY FOR OUT-OF-HOSPITAL ACTIVITY

Date______________

This is to certify that____

is out on leave in company of____

(if patient is not responsible or is a minor) who assumes responsibility for him/her while out of the hospital. The hospital staff and physician are relieved of responsibility during this leave.

Left Unit At__________________

Returned By___________________

Time Returned_________________

____
Signed (Patient or responsible party)

____
Witness

The individual taking the patient from the unit is to accompany the patient back to the unit and notify the nursing personnel.

CHEST PAIN
Page 1

Sample

V - TECS 54
L.A. #7

Admission Date ______ BATH: SELF ASSIST BED
Classification ______
Diet ______
Diet ______
Diagnosis ______
Surgery ______

ATTENDING PHYSICIANS:
______ ______
______ ______
(Addressograph)

Date	Initials	PROBLEM	APPROACH HEALTH	OUTCOME
			1. Take v/s (B/P, apical pulse, T, R), lung, and heart sounds ______	v/s stable for 24 hours prior to discharge
			Notify M.D. of arrhythemia	
		Pain	2. When chest pain occurs chart:	free of chest pain 24 hours prior to discharge
			a. v/s: B/P, apical pulse, R, skin color and temperature	
			b. run rhythm strip if on monitor	
			c. location	
			d. type (i.e., dull, crushing, sharp)	
			e. radiation	
			f. give prn ______	
			Chart relief obtained.	
			g. attempt to elicit precipitating factors such as emotional stress, smoking, increase in physical activity	
			3. Stat EKG if chest pain accompanied by dyspnea, cyanosis, nausea and/or vomiting or crushing, midsternal pain.	
			4. O_2 via ______ @ ______ prn	
			5. Weigh daily ac breakfast and record. Report weight gain in excess of 3 lbs. to M.D.	Weight stable (within 3 lbs.) of previous day's weight.
[illegible]			[illegible]	

9/77

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PATIENT CARE FORM

Admission Date
Classification
Diet
Diet
Diagnosis CHEST PAIN--PAGE TWO
Surgery

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
		Pain on exertion	1. Increase activity according to following schedule:	able to give self care and ambulator 24 hours prior discharge
			2. Observe and record indications of patients tolerance to activity.	
			3. a. Find out usual activity pattern. b. Evaluate patient's ability to tolerate activity (i.e. physical, emotional, or psychological). c. Be aware of anxiety level in association with increased activity and structure activities accordingly.	

Patient's Name:

NAH 2.74

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V - TECS 54
L.A. #7

PATIENT CARE FORM

Admission Date ____________________

Classification ____________________

Diet ____________________

Diet ____________________

Diagnosis CHEST PAIN--PAGE THREE

Surgery ____________________

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
		Date, Initials		
		________	1. Request dietician to visit and discuss diet.	
			________ called ________ visited.	
		________	Risk Factor Booklet given	
		________	Evaluated on understanding and application	
			of risk factors to self	
			2. Discharge instructions:	Patient and/or
			Reinforce information and instructions	significant other
			with patient, and/or spouse or significant other regarding:	verbalizes under-
				standing of dis-
		________	a. activity	charge instruction
		________	b. take home medications	and information.
		________	c. diet	
		________	d. medical follow-up	
		________	e. disease process	
		________	f. avoidance of precipitating factors of chest pain	
		________	g. follow-up appointment	
			Reinforce physician's instructions.	
			Discharge	

Patient's Name:

V-TECS 54
L.A. #9

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Arrange escort and transportation services for therapy elsewhere.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When arranging escort and transportation services for therapy elsewhere, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Correctly interpreted the order.	( )	( )	( )	( )	( )
2. Recorded arrangements made on patient's Kardex ... {or patient care form}...	( )	( )	( )	( )	( )
3. Prepared a charge form.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Arrange for ordered consultations

PERFORMANCE OBJECTIVE

Given the necessary supplies, information, and an order from a patient's physician to arrange for a consultation with another physician, make the necessary calls and prepare forms to be placed on the chart without error. Arrangements made must result in correct physician consulting. (4)

PERFORMANCE GUIDE

1. Interpret the order and transcribe the information to the Kardex ...{or patient care form}... .
2. Notify the charge nurse.
3. Locate and fill in the top section of the "consultation request" form.
4. Verify the exact physician requested and ascertain the correct telephone number.
5. Call the office of the physician requested in consultation to obtain date and time of availability and give the name of the hospital, the patient's name, room number, history number, diagnosis, and physician requesting the consultation.
6. Notify the physician ordering the consultation of date and time.
7. Place the "Report of Consultation" form on chart after filling in the headings.
8. Indicate on Kardex ...{or patient care form}... "done" and note the time consultation is to occur.
9. Initial the order.

LEARNING ACTIVITIES

1. Listen to resource speaker (M.D.) explain the reasons for consulting another physician.
2. Listen to an experienced ward clerk describe the responsibilities of the ward clerk after the physician orders a consultation.
3. Role play in small groups the arranging for ordered consultations.
4. Discuss the clerical duties of the ward clerk after the consulting physician has seen the patient.
5. Under the supervision of an experienced ward clerk, perform the task of arranging for an ordered consultation. A rating of "fully accomplished" must be achieved, based on the instructor's observations.

RESOURCES

physician
experienced ward clerk

TOOLS AND EQUIPMENT
physician's order

EVALUATION
Using provided materials, the student will arrange for an ordered consultation. No errors are allowed. A rating of "fully accomplished" must be achieved, based on the observation of the instructor.

V-TECS 55
L.A. #5

STUDENT______________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Arrange for ordered consultations.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When arranging for ordered consultations, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Transcribed the orders to the Kardex or patient care form.	( )	( )	( )	( )	( )
2. Prepared the consultation request form and placed form on patient's chart.	( )	( )	( )	( )	( )
3. Called physician's office and obtained date and time of consultation.	( )	( )	( )	( )	( )
4. Notified office of physician requesting consultation of date and time.	( )	( )	( )	( )	( )
5. Initialed the order, indicated on Kardex ...{or patient care form}... "done" and noted date and time of consultation.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Discontinue all orders when patient goes to surgery.

PERFORMANCE OBJECTIVE

Given the chart of a patient going to surgery, discontinue all preceding treatment and medication orders in effect at the time and indicate discontinuance on physician's order sheet. Orders discontinued will be those of this patient, and indication of discontinuance will be legible and order sheet will be photocopyable. (4)

PERFORMANCE GUIDE

1. When a patient is ready for surgery, identify and remove from the nurses' work station all medicine and treatment tickets which were prepared for this patient. Note: If Brewer system is used, remove medicine sheet from notebook crossing out remaining space available on the sheet. Place this sheet in the patient's chart.
2. Remove patient's name from diet list.
3. Remove patient's name from activity list.
4. Erase Kardex data for all preceding orders.
5. Note discontinuance of all orders on the doctor's order sheet using appropriate symbols and initial. Note: An assumption has been made that, if this task is sucessfully performed, the student will be able to discontinue other orders as required in the "transcription of orders" process.
6. Enter information into computer if applicable.

LEARNING ACTIVITIES

1. Discuss the procedure (step-by-step) for discontinuing orders (per local health care facility policy).
2. Listen to a resource speaker (e.g., a nurse) explain the **purpose** of the various steps taken to discontinue orders.
3. Simulate a situation in which discontinuance of all orders must occur for a surgical patient. Using transparencies, perform as an entire class the necessary procedure.
4. Review task on transcribing medications to Medication Administration Record (MAR) - (Lesson 15, V-TECS OBJ. #50).
5. Distribute sample groups of postoperative orders and practice transcribing these orders, using all the necessary forms.
6. Under the supervision of an experienced ward clerk, perform the task of discontinuing all orders for a patient going to surgery. A rating of "fully accomplished" must be achieved, based on the observations of the instructor.

RESOURCES

registered nurse
experienced ward clerk

TOOLS AND EQUIPMENT

open patient charts
physician's orders

EVALUATION

Using provided materials and information, the student will discontinue all medication and treatment for a patient going to surgery. No errors are allowed. The indication of discontinuance must be legible and the order sheet must be photocopyable. A rating of "fully accomplished" must be achieved, based on the observations of the instructor.

V-TECS 57
L.A. #6

STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Discontinue all orders when patient goes to surgery.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When discontinuing all orders when patient goes to surgery, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Discontinued all orders on a patient going to surgery.	( )	( )	( )	( )	( )
2. Removed patient's name from all appropriate locations.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Distribute forms and articles from "In" basket

PERFORMANCE OBJECTIVE

Given established policies, Kardex, and an assortment of diagnostic reports, old charts, X-rays, messages, memoranda, etc., distribute each according to priority, and all before the change of the shift, to the appropriate receptor. (4)

PERFORMANCE GUIDE

1. Identify to whom the item belongs or is intended. The "In" basket generally accommodates diagnostic reports, memoranda, thank-you notes, special written messages from physicians or staff, X-rays, old charts, tray favors, patient's bills, insurance forms.
2. Identify whether or not the person is now or was on this unit in the past month.
3. If article is for a patient, check Kardex for patient restrictions.
4. Notify charge nurse of all reports received.
5. Give, post, or route all other items received.

LEARNING ACTIVITIES

1. Discuss the types of forms and articles customarily found in an "in" basket. Write them on the board.
2. Arrange in order of priority (highest to lowest) the listing prepared during learning activity #1.
3. Visit a unit and observe an experienced ward clerk distribute items from the "in" basket to intended destinations. Ask questions, as appropriate.
4. Simulate a unit situation with a filled "In" basket. Distribute the items to their intended destination (identify the "location" verbally) as classmates evaluate appropriateness.
5. Discuss the use of addressograph plates for patients present on unit; on the other hand, emphasize that if no longer a patient, materials should be sent to Medical records.
6. Role play with other students the checking of Patient Care Notebook or Kardex to ascertain if patient may have article.
7. Discuss need to notify charge nurse of important reports received.
8. Discuss what to do if no information can be found on patient (i.e., return items to appropriate department).
9. Perform expediently the task of distributing in order of priority items from "In" basket to appropriate destinations (which may be identified verbally). A rating of "fully accomplished" must be achieved, based on the instructor's observations.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

"In" basket
patient care notebook or Kardex
addressograph nameplate

EVALUATION

Using the materials and information provided, distribute, in order of priority, forms and articles from "In" basket to appropriate destination. A rating of "fully accomplished" must be achieved, based on the observations of the instructor.

V-TECS 58
L.A. #9

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Distribute forms and articles from "in" basket.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When distributing forms and articles from "In" basket, the student:	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Determined distribution priority of the forms and/or articles.	( )	( )	( )	( )	( )
2. Checked Kardex for patient restrictions.	( )	( )	( )	( )	( )
3. Notified charge nurse of all reports received.	( )	( )	( )	( )	( )
4. Distributed, posted or routed appropriate items.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

V-TECS 59

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Execute Pre-op chart check

PERFORMANCE OBJECTIVE

Given a Pre-op chart check list ...{or a surgery packet}..., a patient going to surgery, and his/her chart, determine whether chart is complete and up-to-date, identify discrepancies, and present to charge nurse for follow-up. Determination must agree with the instructor's findings. (4)

PERFORMANCE GUIDE*

1. Obtain Pre-op chart check list and surgery packet.
2. Imprint all items in surgery packet and the check list, place in front of chart, or send patient's addressograph plate with chart.
3. Determine that: History and physical was written, operative or other needed permits were signed, all orders were noted, patient's weight was recorded. TPR and BP just before surgery was recorded, current CBC and UA reports are on chart (within 48 hours), doctor was notified of low hemoglobin, blood is available if ordered, allergies or phobias are recorded, surgical prep was charted and noted by whom signed, dentures were accounted for, Pre-op medication charted, consultation forms were completed, removal of jewelry and hair pins charted, relatives were notified of surgery time, finger nail polish and lipstick removal was charted, date and time of last food or drink was charted, medicated bath and oral hygiene was charted, voiding or catheter insertion was charted, chest X-ray has been done and report is on chart, {EKG has been done and report is on chart}, pregnancy test has been done on all female laparotomy patients and recorded.
4. Notify charge nurse of any discrepancies for follow-up.
5. Submit list to nurse for her signature and place in front of chart.

* South Carolina writing team suggests a revised listing. Refer to the following revised performance guide.

SOUTH CAROLINA PERFORMANCE GUIDE

1. Obtain surgery packet.
2. Imprint all items in surgery packet, place in front of chart and send patient's addressograph plate with chart.
3. Determine that: History and physical were written; operative or other needed permits were signed; all orders were noted; patient's weight was recorded; TPR and BP within 24 hours prior to surgery were recorded; most current CBC and UA reports are on chart (within 48 hours). (Chest X-ray has been done and report is on chart. EKG has been done and report is on chart, if necessary.)
4. Notify charge nurse of any discrepancies for follow-up.
5. Submit list to nurse for signature and place in front of chart.

LEARNING ACTIVITIES

1. Display and study the contents of a surgery packet. Discuss the purpose of each form. The surgery packet contains the following sample forms: a) "Consent to Operation, Anesthetic and Other Medical Services," b) "Anesthesia Record," c) "Preoperative Checklist," d) "Fluid Administration Form," and e) "Frequent Observation Record" (attached).
2. Practice imprinting all forms which belong in chart.
3. Practice placing chart forms, physician's orders to transcribe, and other appropriate forms in chart.
4. Visit a unit to observe an experienced ward clerk executing a pre-op chart check. Ask questions as appropriate.
5. In a mock situation, perform the task of executing a pre-op chart check, according to the items listed in the instructor's checklist. A rating of "fully accomplished" must be achieved.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

surgery packet
patient's chart
writing tools

EVALUATION

Using materials provided, the student will determine whether the chart of a pre-operative patient is complete and up-to-date, identify discrepancies, and present to charge nurse for follow-up. Accuracy must be 100%. A rating of "fully accomplished" must be achieved on the instructor's checklist.

V-TECS 59
L.A. #1.a.

CONSENT TO OPERATION, ANESTHETIC AND OTHER MEDICAL SERVICES

Date ______________________

Time ______________________ am
pm

1. I authorize the performance upon ______________________
(myself or name of patient)

   of the following operation ______________________
   (state nature and extent of operation)

   to be performed under the direction of Dr. ______________________ and/or such assistants as may be selected by him to perform such operation.

2. I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures or services than those set forth above and I further authorize and request that the above-named surgeon and/or his associates, partners, assistants or designees perform such procedures as are, in his professional judgement, necessary and desirable.

3. I consent to the administration of such anesthetics as may be considered necessary or advisable by the person responsible for such service.

   State any known anesthesia allergies: ______________________

4. I consent to the disposal by hospital authorities of any tissue or members which may be removed during the course of the operation.

5. The nature, purpose and possible consequences of the operation, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me by my attendig physician and/or surgeon. No guarantees or assurances have been made or given by anyone as to the results that may be obtained.

6. I, THE UNDERSIGNED, HAVE HAD THIS FORM EXPLAINED TO ME AND FULLY UNDERSTAND THE CONTENTS OF THIS AUTHORIZATION.

Signed ______________________
(patient or authorized person)

Witness ______________________

____
(relationship)

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V - TECS 59
L.A. #1.b.

ANESTHESIA RECORD

Date	NPO	PHYS. STATUS
PREMEDICATION (DRUGS, DOSE, TIME, EFFECT)		

BUSINESS DATA PLATE

15 30 45 15 30 45 15 30 45 15 30 45 15 30

Agents N_2O / O_2

FLUIDS

BLOOD LOSS

B.P. V Λ	°C	
		240
Pulse •	38	220
	36	200
Start Anes. X	34	180
	32	160
Start Op. ⊙	30	140
End Anes. ⊗		120
		100
Temp Δ		80
Suct. S		60
		40
Rec. Room R		20
Resp. O	Spon.	10
	Asst.	
	Cont.	

SYMBOLS

AGENTS	DOSAGE	TECHNIQUES
A.		
B.		
C.		
D.		
E.		
F.		
G.		
FLUID SUMMARY		BLOOD LOSS
		URINE
		Anesthesia Time

Monitors: BP ________ Stethoscope ________ EKG BAM

Temp ______ foley, CVP, Swan Ganz, O_2 Monitor

Airway/endotracheal tube ________

OPERATION

SURGEON

ANESTHESIOLOGIST

Form 20-881-001 (Rev. 1/82)

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V - TECS 59
L.A. #1.b.

PRE-ANESTHESIA EVALUATION

Date: ____________ **Proposed Operation** ____________

Age: ____________ **Weight:** ____________

PERTINENT HISTORY AND PHYSICAL FINDINGS

NO	YES	
☐	☐	**CARDIOVASCULAR** (MI, Angina, CHF, Valvular, High BP)
☐	☐	**PULMONARY DISEASE** (Asthma, COPD)
☐	☐	**CNS, NEUROMUSCULAR** (CVA, Seizures, Mental status)
☐	☐	**RENAL DISEASE** (Kidney failure)
☐	☐	**HEPATIC DISEASE** (Hepatitis, Cirrhosis)
☐	☐	**ENDOCRINE** (Diabetes, Thyroid)
☐	☐	**HEMATOLOGICAL** (Anemia, Sickle cell, Bleeding disorder)
☐	☐	**ORAL CAVITY** (Loose teeth, Dentures, Difficult Airway)
☐	☐	**PREVIOUS PROBLEMS WITH ANESTHESIA**
☐	☐	**ALLERGIES TO MEDICATIONS**
☐	☐	**CURRENT MEDICATIONS**
☐	☐	**OTHER**

PERTINENT LAB:

ASA PHYSICAL STATUS: CLASS 1, 2, 3, 4, 5, E

ANESTHETIC PLAN: PATIENT AGREES TO: ____________

____________ M.D.

CONDITION ON ADMISSION TO PAR

LEVEL OF CONSCIOUSNESS	RESPIRATORY EFFORT	AIRWAY	VITAL SIGNS
Awake	Adequate	Adequate airway	BP
Arousable on calling	Inadequate	Oral or nasal airway	P
Not responding	Ventilator	Endotracheal tube	R

APPARENT COMPLICATIONS

____________ CRNA

____________ MD

V-TECS 59
L.A. #1.c.

(Addressograph)

Nurses Initials

1. Operative permit signed and properly witnessed.________________

2. CBC on chart.____________ ____________________

3. Urinalysis on chart.__________________________

4. Physician notified of abnormal lab/x-ray reports.______________

5. Bleeding and coagulation time on chart of T&A patient, (if ordered).____

6. Blood typed and crossmatch. Yes___ No___ pts.______________

7. History and physical exam on chart____ or dictated____________

8. Notify PM administrator if H&P not on chart by 9 p.m.____________

9. Consultation sheet signed and on chart as required by hospital policy.___

10. Special permits signed and properly witnessed as required by hospital policy.________ ________

11. Religion of patient is__________________________

12. Anesthesia sheet on chart.________________________

13. Pre-op teaching done. Peds party___ Gyn class___ Individual________

14. Identification bracelet on and legible.__________________

15. TPR and BP are charted._________________________

16. Cosmetics, hairpins, hairpieces, wigs, artificial eyelashes removed.____

17. Dentures___ Partial Plates___ Bridges___ Caps________ __________

18. Contact lens Yes___ No___ Placed_____________________

19. Mouth checked for chewing gum, mints, etc.

20. Jewelry Yes___ No___ Placed ________________________

21. Complete recheck of Doctor's pre-operative orders.____ __________

22. Addressograph plate with chart.______________________

23. MAR on chart.__ ______________________________

24. Patient care form on chart.______________________________

25. Urinary bladder emptied____ Catheter inserted______________________

26. Re-check operative permit pre-op being given.____________________

Date ______________ AM Nurse's Signature ____________________

OR-Holding Room

27. Patient received in Holding Room at am/pm _______ _____________

28. Shave completed by ______________________________________

29. Chart checked by ____________________ and ____________________
Holding Room Personnel Circulating Nurse

V - TECS 59
L.A. #1.d.

FLUID ADMINISTRATION FORM

Addressograph

DATE	TIME	NURSE	SOLUTION-BLOOD	NEEDLE/DEVICE & SIZE, SITE	RATE	AB-SORBED	IV TUBING CHANGED	COMMENTS

DATE	INITIALS	IV FLUIDS AND BLOOD ORDERS

V - TECS 59
L.A. #1. e.

FREQUENT OBSERVATION RECORD

(ADDRESSOGRAPH)

Date/ Hour	Blood Pressure		Pulse	Resp.	Temp.	INTAKE			OUTPUT		
						I.V.	Other		Urine	Other	

FORM N412-4 (4-73)

V-TECS 59
L.A. #4

STUDENT ______________________________

DATE ______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Execute pre-op chart check.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When executing pre-op chart check, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Obtain a surgery packet containing all forms.	( )	( )	( )	( )	( )
2. Properly imprinted all forms and explained the purpose of each.	( )	( )	( )	( )	( )
3. Placed packet in front of chart.	( )	( )	( )	( )	( )
4. Transcribed physician's orders correctly.	( )	( )	( )	( )	( )
5. Secured all necessary forms and reports; placed in proper chart position.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Prepare laboratory requisition form(s)

PERFORMANCE OBJECTIVE

Given a doctor's order for a laboratory diagnostic procedure such as "arthritis profile," ...{or urinalysis}... appropriate equipment, and forms, prepare the required requisition form(s). Each form must be prepared without error or omission. All forms must be judged acceptable for processing by laboratory personnel. (4)

PERFORMANCE GUIDE

1. Translate and identify the order, annotate Kardex ...{or patient care form}... .
2. Select appropriate form(s).
3. Select addressograph plate and imprint form(s). Note: Correct patient vitally important!
4. Fill in all needed information including home address if needed, diagnosis, BP and medication, using ball point pen and heavy writing pressure.
5. If order is STAT, notify lab by telephone.
6. If order is for a later date, prepare requisition and place in Kardex (to be sent later).
7. Information may be entered in computer memory bank ..{if applicable}... .
8. Locate all routine preparation orders associated with the order being transcribed in the ward clerk or laboratory manual.
9. Notify kitchen of dietary changes or holds due to lab work.
10. Write the preparation order on Kardex and requisition the supplies.
11. Transcribe to the Team Leader sheet ...{or the schedule for patient treatment form}... .
12. Have charge nurse initial requisitions.
13. Prepare specimen labels and containers if indicated as follows:
    a. Identify type of specimen container(s) needed (stool, urine, nose-throat-wound-drainage cultures, gastric analysis, pap smear, sputum, vomitus, biopsies, bile, semen, sweat, spinal fluid, bone marrow, ascities, saliva).
    b. Identify type of label needed.
    c. Print patient's name, doctor's name, room number, type of contents and time of collection on label. Note: May sometimes need to indicate how obtained.
    d. Give label and container to nurse to prepare specimen.
    e. Prepare correct requisition completely to accompany specimen.
14. Route requisition and specimen to lab, making sure it is charted on the nurse's notes and signed by the nurse. Clock in.
15. File the floor copy of the requisitions.

LEARNING ACTIVITIES

1. Discuss the purpose and use of the attached sample patient care form and laboratory requisitions.
2. Demonstrate transcription of physician's order concerning laboratory requests (& proper placements).
3. Discuss purpose and use of attached sample schedule for patient treatment form.
4. Research and prepare a report describing the types of specimens that are routinely sent to each laboratory division for analysis.
5. Review medical laboratory terms and abbreviations commonly used in the local health care facility.
6. Practice transcribing several physician's orders and preparing appropriate laboratory requisitions and specimen labels.
7. Discuss the important regulations regarding the use, completion, and delivery of laboratory requisition forms. For example: If data processing cards are used, they are not to be folded, bent, or stapled.
8. Visit a laboratory department to observe the activities of the clerical personnel with whom the ward clerk coordinates.
9. Prepare a list of all laboratory tests which require prior preparation of the patient. Write (for use later as a reference) a description of the preparation necessary for each test. For example: The ward clerk may need to cancel or requisition special meals from the kitchen.
10. Visit a unit to observe an experienced ward clerk prepare a laboratory requisition form.
11. Perform the task (in a simulated classroom setting) of preparing a laboratory requsition form for a urinalysis. Follow the steps outlined in the instructor's checklist. A rating of "fully accomplished" must be achieved.

RESOURCES

laboratory personnel
experienced ward clerk

TOOLS AND EQUIPMENT

physician's order
appropriate forms
addressograph plate
writing tools (including a ball point pen)

EVALUATION

Using provided information and materials, the student will identify and prepare laboratory requisition form(s) for a "urinalysis" order. No errors or omissions are allowed. The performance must warrant a rating of "fully accomplished," based on the items included in the instructor's checklist.

PRE-OPERATIVE PATIENT FOR ADULT SURGERY

V - TECS 61
L.A. #1

Admission Date ______ BATH: Self Assist Bed
Classification ______
Diet ______
Diet ______
Diagnosis ______
Surgery ______

Attending Physician(s):

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			Vital signs (T, P, R, and BP) on admission and @ HS prior to surgery and AM of surgery. Prepare for surgery as ordered:	Afebrile (less 99.6) 12 hours prior to surgery Establishment o baseline vital signs.
			Up ad lib unless contraindicated.	Ambulatory
			1. Give verbal and/or written explanation of preparation for surgery and of post-op care.	Verbalizes instructions regarding procedures and coope
			2. Explain operative permit to patient and witness patient's signature.	with plan of ca Informed consen

PATIENT CARE FORM
318

R 7/79

FOR: Appendectomy Post ICU Gastrectomy Abdominal Surgery, Adult
Hernia Exploratory Laparptory
Pilonidal Cyst Cholecystectomy

V - TECS 61
L. A. #1

Admission Date ________________ BATH: Self Assist Bed

Classification ________________

Diet ________________

Diet ________________

Diagnosis ________________

Surgery ________________ Page 1

Attending Physician(s):

________________ ________________

________________ ________________

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			1.A. Vital signs (T, P, R, and BP) every 4 hrs.	Afebrile (temp
			x 72 hours.	less than 99.6
			B. DC at ______ am/pm on ______________.	24 hrs. prior
			Then routine q ____________ hrs.	discharge.
			C. Turn, cough, deep breathe every 2 hrs.	
			x 24 hours.	
			Assist patient to splint incision as	
			necessary.	
			2.A. Check dressing(s) every 4 hrs. x 24, then	Clear healing
			QID	wound.
			B. If prn dressing change order:	
			Change dressing at least daily to observe	
			wound area for redness, swelling, increased	
			drainage, healing.	
			C. Note presence of:	
			Drain ____________ Removed ____________	
			Skin clips ____________ Remove ____________	
			Staples ____________ Remove ____________	
			Sutures ____________ Remove ____________	
			Steri-strips ________________________	
			T-tube ______ Empty ______ Removed ____________	
			Hemovac ______ Empty ______ Removed ____________	
			Other ________________________	

PATIENT CARE FORM

FOR: Appendectomy Cholecystectomy Abdominal Surgery, Adult
Hernia Post ICU Gastrectomy
Pilonidal Cyst Exploratory Laparotomy

V - TECS 61
L. A. #1

Admission Date BATH: Self Assist Bed

Classification

Diet

Diet

Diagnosis

Surgery Page 2

Attending Physician(s):

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			3.A. I & O every 8 hrs.	Normal bladder
			B. DC at ______ am/pm on ______	function restor
			if voiding freely and taking po fluids.	
		(Cath order)		
			4. Levine tube ______ Salem sump ______	Bowel function
			Connect to ______	restored (1 BM
				prior to dischar
			Irrigate with ______	Tolerating diet
			Remove NG tube (date) ______	
			5.A. Elevate foot of bed 3" x 8 hrs. (if ordered)	
			B. Lower foot of bed at ______ am/pm	
			on ______.	
		(Ambulation orders)		Ambulatory

FOR: Appendectomy Cholecystectomy Abdominal Surgery, Adult
Hernia Post ICU Gastrectomy
Pilonidal Cyst Exploratory Laparotomy

Admission Date ____ BATH: Self Assist Bed

V - TECS 61
L. A. #1

Classification ____

Diet ____

Diet ____

Diagnosis ____

Surgery ____ Page 3

Attending Physician(s):

____ ____

____ ____
(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			Discharge____	
			6. Instruct patient and/or significant other	
		(Date and Initials)	in the following:	Patient verbali
		____	A. Follow-up appointment____	understanding a
		____	B. Activity limitations	or demonstrates
		____	C. Wound Care	discharge instr
		____	D. Take home drugs	tions.
			E. Special diet	
			Reinforce physician's instructions	

PATIENT CARE FORM
321

333

[These types of forms are color coded.]

V - TECS 61
L. A. #1

REQUESTED BY: ORDERED BY M.D.

SPECIMEN:					
EXAMINATION REQUESTED:					
DEPT.	CODE	TEST			
X X	X X				
X X	X X				
X X	X X		DATE	TIME ☐ AM ☐ PM	COLLECTED BY
X X	X X				
X X	X X				
X X	X X				
X X	X X				
LABORATORY MISCELLANEOUS	DATE:	PATHOLOGISTS:	TECH.	CHARGE	

CALLED TO TIME: ☐ AM ☐ PM DATE: BY

LABORATORY MISCELLANEOUS

EXAM REQUESTED:	PATIENT'S RESULTS:	NORMAL:
☐ ANA		< 1:20
☐ STREPTOZYME		NEGATIVE
☐ ASO TITER		Preschool & Adult ≤ 166 T U School Age ≤ [illegible] T U
☐ COLD AGGLUTININS		< 1:16
☐ MONOTEST		NEGATIVE
☐ RA TEST		NEGATIVE
☐ RPR ☐ VDRL (STS)		NONREACTIVE
☐ FEBRILE AGGLUTININS	BRUCELLA ABORTUS	
	PROTEUS OX-19	
	TYPHOID O	
	TYPHOID H	
	PARATYPHOID A	
	PARATYPHOID B	
DATE	TECH	PATHOLOGISTS

DATE	TIME ☐ AM ☐ PM	COLLECTED BY
☐ STAT ☐ ROUTINE		< = LESS THAN; > = GREATER THAN
ORDERED BY:		
REQUESTED BY:		
LAB REMARKS:		

REPORT CALLED TO TIME ☐ AM ☐ PM DATE BY

SEROLOGY

PATIENT'S CHART

DO NOT WRITE IN THIS SPACE - FOR LAB USE ONLY

DATE ______ TIME ______ AM. OF PM. COLLECTION		ROUTINE ☐ STAT ☐	
ROUTINE URINALYSIS ☐	VOIDED ☐	CATH. ☐	STERILE ☐
OTHER TESTS: ☐	MICROSCOPIC ☐	ADMISSION ☐	
REMARKS:			
NURSE:	ORDERED BY		M.D.
SP.G.	COLOR	W.B.C.	/hpF
pH		R.B.C.	/hpF
ALBUMIN:		CASTS:/LpF	
GLUCOSE:	REDUCING SUBSTANCE	BACTERIA:	
KETONES:		EPI CELLS:	
BILIRUBIN:		CRYSTALS:	
BLOOD:		MUCOUS:	
LABORATORY URINALYSIS	DATE	PATHOLOGIST:	TECH

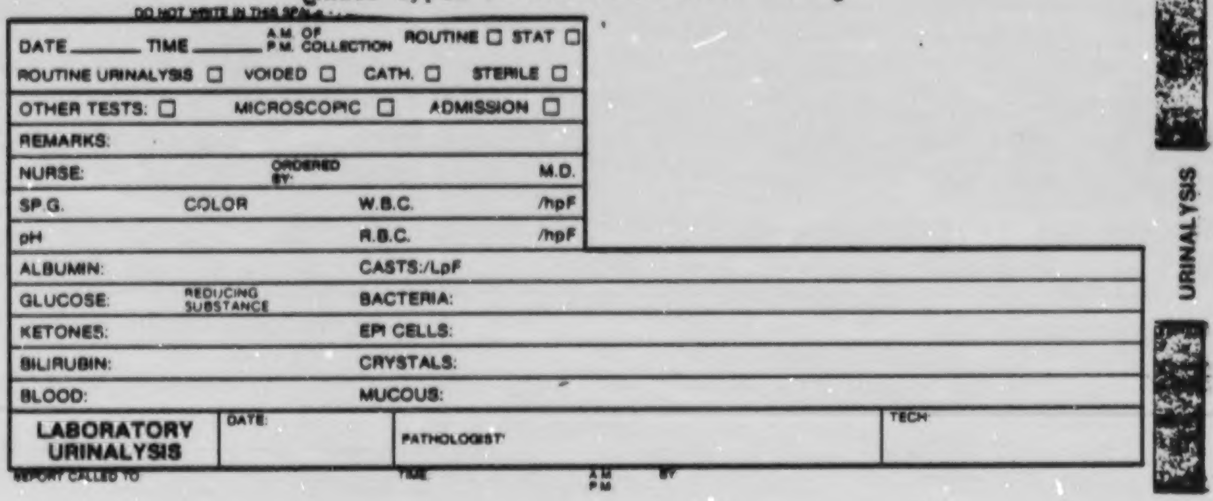
REPORT CALLED TO TIME AM PM BY

URINALYSIS

PATIENT'S CHART

BEST COPY AVAILABLE

[These types of forms are color coded.]



DO NOT WRITE IN THIS SPACE

DATE ______ TIME ______ A.M. OF P.M. COLLECTION ROUTINE ☐ STAT ☐

ROUTINE URINALYSIS ☐ VOIDED ☐ CATH. ☐ STERILE ☐

OTHER TESTS: ☐ MICROSCOPIC ☐ ADMISSION ☐

REMARKS:

NURSE: ORDERED BY: M.D.

SP.G. COLOR W.B.C. /hpF

pH R.B.C. /hpF

ALBUMIN: CASTS:/LpF

GLUCOSE: REDUCING SUBSTANCE BACTERIA:

KETONES: EPI CELLS:

BILIRUBIN: CRYSTALS:

BLOOD: MUCOUS:

LABORATORY URINALYSIS DATE: PATHOLOGIST: TECH:

REPORT CALLED TO TIME A M P M BY

URINALYSIS

PATIENT'S CHART

MOUNT ONLY COULTER HEMATOLOGY REPORTS ON THIS SHEET

V - TECS 61
L. A. #1

☐ CBC ☐ PROFILE
ORDERED BY:

11/[illegible]

TECH:

WBC x 10³	M F 7.8 ± 3	5.6
RBC x 10⁶	M 5.4 ± 0.7 F 4.8 ± 0.6	4.32
Hgb g/dl	M 16.0 ± 2 F 14.0 ± 2	13.6
Hct	M 42 – 52 F 37 – 47	.39 3
MCV µm³	M 87 ± 7 F 90 ± 9	90.8
MCH pg	M F 29 ± 2	31.5
MCHC g/dl	M F 35 ± 2	34.7
RDW %	*	12.2
PLT x 10³	M F 130-400	324.
		7.5
		17.
		1.0

☐ PLATELET COUNT NOT VERIFIED

☐ SEE REMARKS ☐ SEE SEPARATE FORM

TECH:

DIFF		MORPH	
	BASO.	POLYCHROM	
	EOS	HYPOCHROM	
	MYELO	POIK	
	META	ANISO	
	BAND	BASO STIP	
	SEG	TARGET	
	LYMPH		
	MONO		
		TOXIC GRAN	
		DOHLE BODIES	
	NRBC PER 100 WBC	RETIC COUNT 0.5-1.5%	
	SED. RATE UNC	ABSOLUTE RETIC CT 25-75 x 10³/µl	
	SED. RATE COR		

☐ CBC W/PLATELET ☐ PLATELET W/PROFILE
☐ DIFF ☐ RETIC ☐ SED RATE ☐ MICRO HCT

ORDERED BY: M.D. NURSE: DATE:

TEST NO

NORMAL VALUES

REPORT CALLED TO:

TIME AM PM BY

ROUTINE ☐ STAT ☐
TODAY ☐ ADM ☐
STAT DRAW
RUN ROUTINE ☐

TIME TO BE DRAWN ___ AM PM
REPORT NEEDED BY ___ AM PM

REMARKS

DATE DRAWN

TIME AM ☐ PM ☐

COLLECTED BY

[redacted] L [redacted] [redacted] [redacted] [redacted] P [redacted] PATIENT'S CHART [redacted]

HOSPITAL FORMS

HEMATOLOGY LABORATORY REPORTS

324 336

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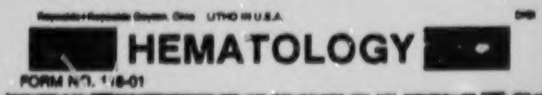
V - TECS 61
L. A. #1

These types of forms are color coded.

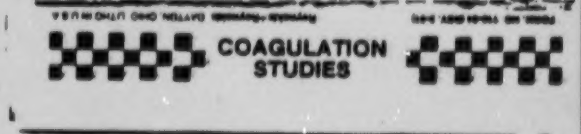
LABORATORY REQUISITIONS

HEMATOLOGY

118-01 Hematology....................................

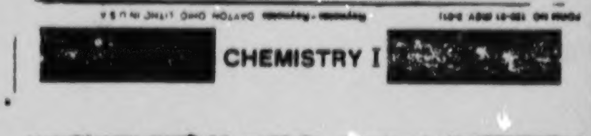

HEMATOLOGY
FORM NO. 118-01

118-02 Coagulation Studies...............................

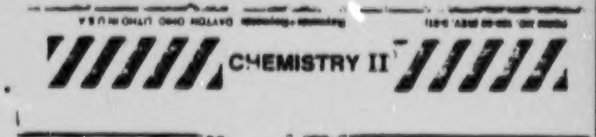

COAGULATION STUDIES

CHEMISTRY

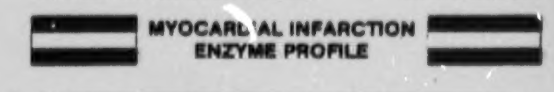
120-01 Chemistry I..


CHEMISTRY I

120-02 Chemistry II.......................................

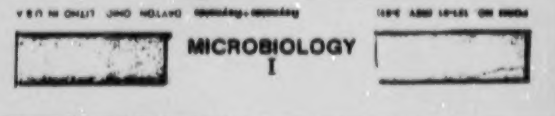

CHEMISTRY II

120-03 Myocardial Infarction Enzyme Profile............

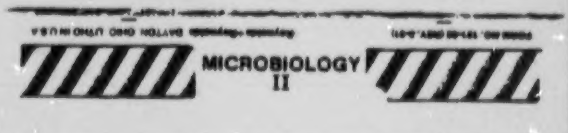

MYOCARDIAL INFARCTION ENZYME PROFILE

MICROBIOLOGY

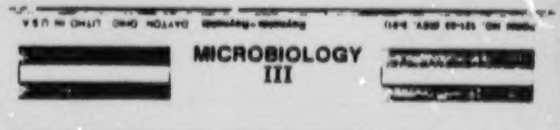
121-01 Microbiology I.....................................


MICROBIOLOGY I

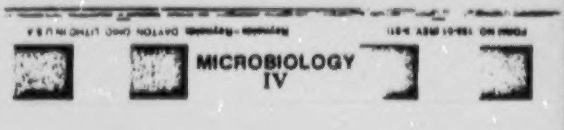
121-02 Microbiology II....................................


MICROBIOLOGY II

121-03 Microbiology III...................................

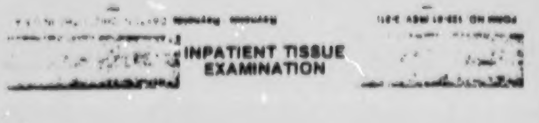

MICROBIOLOGY III

133-01 Microbiology IV....................................


MICROBIOLOGY IV

HISTOLOGY

122-01 Inpatient Tissue Examination...................


INPATIENT TISSUE EXAMINATION

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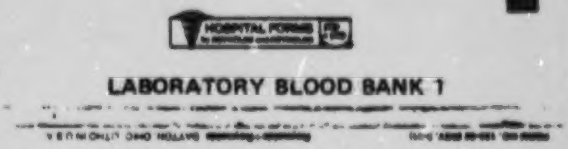
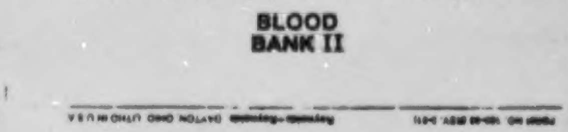
BLOOD BANK

123-01 Blood Bank I....................................



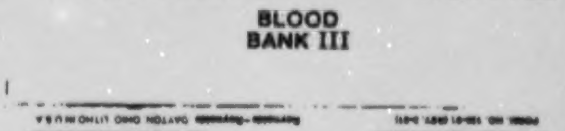
LABORATORY BLOOD BANK 1

123-02 Blood Bank II....................................



BLOOD
BANK II

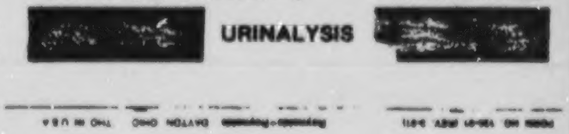
123-03 Blood Bank III....................................



BLOOD
BANK III

URINALYSIS

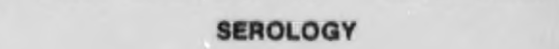
125-01 Urinalysis....................................



URINALYSIS

SEROLOGY

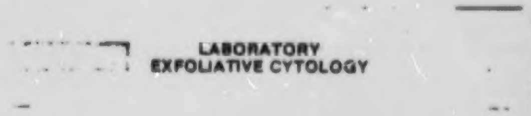
135-01 Serology....................................



SEROLOGY

CYTOLOGY

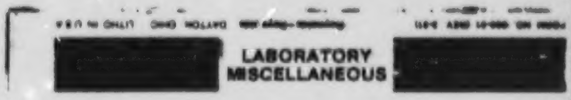
136-01 Laboratory Exfoliative Cytology.................



LABORATORY
EXFOLIATIVE CYTOLOGY

MISCELLANEOUS

199-01 Laboratory Miscellaneous........................



LABORATORY
MISCELLANEOUS

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V - TECS 61
L.A. #3

SCHEDULE FOR PATIENT TREATMENT

DATE______________________ UNIT______________________

DEPARTMENT

Rm #	Patient	NPO	Surg.	Laboratory	EKG	X-ray	Nucl Med.	Cat Scan	P.T.	Time Leaving	Return Time	Chart	Initial	R.R. Time

V-TECS 61
L.A. #10

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare laboratory requisitions form(s).

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing laboratory requisition forms, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Translated and identified orders.	( )	( )	( )	( )	( )
2. Selected appropriate forms and imprinted with addressograph plate.	( )	( )	( )	( )	( )
3. Notified laboratory by phone if order is STAT.	( )	( )	( )	( )	( )
4. Placed forms in appropriate location for transporting to laboratory.	( )	( )	( )	( )	( )
5. Notified kitchen of dietary changes or holds due to lab work.	( )	( )	( )	( )	( )
6. Wrote request in appropriate area on sample schedule for Patient Treatment Form.	( )	( )	( )	( )	( )
7. Prepared specimen labels and containers if indicated.	( )	( )	( )	( )	( )
8. Sent requisition and specimen to laboratory.	( )	( )	( )	( )	( )
9. Filed the floor copy of the requisitions.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Place/remove special bedside directives

PERFORMANCE OBJECTIVE

Given required information, appropriate signs ...{or tapes}... and three patients booked for surgery, designate appropriate signs for the patient's bedside ...{or door}... and indicate anticipated time of removal. Signs posted must be consistent with patient's needs at all times. (4)

PERFORMANCE GUIDE

1.* Identify all needs for special signs ...{or tapes}... from Kardex ...{or patient care form}... and doctors' orders: radioactive materials, oxygen, no smoking, no visitors, isolation, hold breakfast, NPO, surgery.
2.* Select appropriate signs ...{or tapes}... .
3. Inform patients via intercom in understandable terms and using a pleasant tone of voice.
4. Send or take signs to correct bedside table or door.
5. See that food and water are removed from bedside at the proper time.
6.* Make certain that dietary department is notified or hold/NPO.
7. Place patient's name on surgery list, NPO list, etc.
8. Annotate Kardex.
9.* Collect or have signs collected from patient's bedside when no longer needed!

* South Carolina writing team suggests that performance guides 1, 2, 6, 9 reflect responsibilities of the ward clerk. The other items are apt to be handled by the nursing staff.

LEARNING ACTIVITIES

1. Review physician's orders and attached sample patient care form to learn how directives are written.
2. Visit a unit to learn where signs/tapes are.
3. Identify and discuss the purpose of each sign/tape.
4. Read for recall on a test the attached information sheet titled "P.M. Ward Clerk," a sample of the additional responsibilities which are expected with night shift.
5. Role play calling dietary department (give name, title, unit, patient's name, room number) and request "hold" diet. Emphasize the additional responsibility of the p.m. ward clerk {i.e., write NPO on Dietary Requisition (sample attached)}.
6. Review physician's orders and patient care form to learn how directives are cancelled.
7. In a simulated hospital setting, perform the task of placing bedside/door directives for three pre-operative patients. Verbally

indicate when the sign/tape should be removed. A rating of "fully accomplished" by the instructor must be earned.

TOOLS AND EQUIPMENT

patient care form
physician's order
appropriate signs/tapes

EVALUATION

Using provided equipment, supplies, and information, the student will select appropriate bedside/door directives for three pre-operative patients and indicate when sign/tape will be removed. Accuracy and completeness are required. A rating of "fully accomplished" must be achieved, based on the observations of the instructor.

PRE-OPERATIVE PATIENT

V - TECS 62
L.A. #1

Admission Date ____________ BATH: Self Assist Bed

Classification ____________

Diet N.P.O - Midnight.

Diet ____________

Diagnosis ____________

Surgery ____________

Attending Physician(s):

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			Vital signs (T, P, R, and BP) on admission and	Afebrile (less t
			@ HS prior to surgery and AM of surgery. Pre-	99.6) 12 hours
			pare for surgery as ordered:	prior to surgery
				Establishment of
				baseline vital
				signs.
			Up ad lib unless contraindicated.	Ambulatory
			1. Give verbal and/or written explanation of	Verbalizes
			preparation for surgery and of post-op care.	instructions
				regarding proce-
				dures and coopera
			2. Explain operative permit to patient and	with plan of care
			witness patient's signature.	Informed consent.

V-TECS 62
L.A. #4

PM WARD CLERKS
ADDITIONAL RESPONSIBILITIES

1. **Menus:** Stick with patient's name; refer to guide in dietary envelope.

2. **Dietary Requisition:** Refer to patient care form for correct diet. Write in the patient's name, room number and bed. Check correct diet.

3. **Schedule for Patient Treatment:** Refer to patient care form. Write patient's name, room number and bed. Check what the patient is scheduled for: test and/or treatment.

4. **Census Sheet:** Census book - complete and take to Admitting by 10:30 PM.

5. **Charts:** At least 10-20 surgery sheet - for new admissions.

6. **S.P.D. Cart:** Check cart that patient is charged for used items.
AM-PM

7. **Twenty-Four Hour Record of Patient Temperature:** TPR clipboard. Room and bed number with patient's last name.

8. **Controlled Drug Charge Requisitions:** Check controlled drug book or medicine drawer for drug charge requisitions. Stamp the drug charge requisitions with the patient's addressograph card and place in the transportation basket.

9. **Drug Renewal Procedure:** Check Medication Adm. record for expired drugs. Carry out procedures.

10. **NPO Stickers:** It is the responsibility of the Ward Clerk to make out the NPO/HOLD BKFT stickers and the responsibility of the Nursing Assistant to place the stickers on the patient's door.

Room #
Lab.
HOLD BREAKFAST

Room #
NOTHING BY MOUTH

Surgery

V - TECS 62
L.A. #5

DIETARY DIET ORDER REQUISITION

CARBON NOT REQU

By: Your name, title R.N.

Floor:

Date:

A.M.: 4:30
Call Time — D & S
10.00 A.M. & 3:00 P.M.

1 Room No.	2 Name	3 Hold, etc.	4 Full (Regular)	5 Soft	6 LIQUIDS Surg.	7 LIQUIDS Full	8 Special Diets.	9 Dinner Check
372	Newman	(Use Red Ink)	✓					
373	Smoak			✓				
374	Ham				✓			
375	Mills					✓		
376	Smith	HOLD / LAB	✓					
377	Bass	HOLD / X-ray	✓					
378	Ring	HOLD / surg		✓				
379	Davis	NPO						
380	Doan	NPO / LAB						
381	Jones	LAB / no order						
382	Pope	Surg / NPO	✓				ISOLATION	
383	White						8th day Sippy	
384	Paul						↓ salt	
385	Day						2 gm Na	
386	Cox						2 gm Sodium	
387	Olson						1 gm Na	
388	Reese						2 gm Salt	
389	Hucks						Salt Free	
390	Coates						1200 cal ADA 1/5, 2/5,	
391	Watts						1000 cal c̄ H.S. sna	

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V-TECS 62
L.A. #7

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Place/remove special bedside directives.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
When placing/removing special bedside directives, the student:					
1. Placed/removed bedside door directives for selected patient.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

V-TECS 63

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Prepare and route medication index forms ...{or Medication Administration Record}...

PERFORMANCE OBJECTIVE

Given the charts of forty patients and the necessary forms and materials, prepare and route index form ...{or Medication Administration Record}... for each patient. Preparation of the forms must conform to the instructions on the form, must be accurate and legible. (4)

PERFORMANCE GUIDE

1. Obtain medicine index form ...{or MAR}... and addressograph it. Note: The purpose of this form is additional insurance against drug interactions occurring. Most hospital pharmacists wish to contribute their expertise to patient safety in the above manner. In some hospitals, the pharmacist receives a duplicate copy of every physician's order and compiles the medication index forms, in which case the ward clerk would place the prepared index on the patient's chart.
2. From the medication sheet, locate the names of the drugs being given to the patient (including IV's).
3. Place the name, amount, route, and frequency of administration of each drug that the patient is receiving on the form.
4. Place the original of the form on the inside front cover of the chart.
5. Send duplicate of the form to the pharmacy.
6. Add or delete information as orders change.
7. Prepare and route a new form when duplicates on form run out if using a chemically treated carbon set.

LEARNING ACTIVITIES

1. Distribute the attached three information sheets related to medication. Study for recall on a teacher-prepared matching test. Exchange papers and correct each other's work in class.
2. Using a transparency of the sample Medication Administration Sheet (attached), discuss the purpose of this form and how to prepare it.
3. Using a transparency of the sample physician's order (attached), discuss how medication directives are secured by the ward clerk.
4. Outline on board the procedure for routing a copy of the physician's order to the pharmacy. (i.e., Tear out and send through pneumatic tube system.)
5. Discuss and role play the procedure for ordering IV medications (sample forms attached).
6. Visit a unit to observe an experienced ward clerk prepare (and route) a Medication Administration Record. Ask questions as appropriate.

7. In a simulated hospital setting, perform the task of preparing and routing MARs for each of forty patients. A rating of "fully accomplished" must be achieved, based on the observations of the instructor.

TOOLS AND EQUIPMENT

physician's order
Medication Administration Record or other appropriate form

EVALUATION

Using the information and materials provided, the student will prepare a Medication Administration Record for each of forty patients according to the instructions on the form. Preparation must be 100% accurate and legible. A rating of "fully accomplished" by the instructor must be earned.

TYPICAL TIMES of MEDICATION ADMINISTRATION

Times	Abbreviations
every day	q.d.
twice a day	b.i.d.
three times a day	t.i.d.
four times a day	q.i.d.
every other day	q.o.d.
every ___ hours	q. ___ h.
at hour of sleep (once only)	h.s.
before meals	a.c.
after meals	p.c.
at once, without delay	Stat.
when necessary or required	p.r.n.
may be repeated once if necessary	s.o.s.

MEDICAL QUALIFYING PHRASES

PHRASES	ABBREVIATIONS
with	$\bar{c}$
without	s
freely, as desired	ad. lib.
of each	$\overline{aa}$
do not repeat	non. rep.
quantity not sufficient	q.n.s.

Abbreviations for Measures of Drug Dosages

TERMS	ABBREVIATIONS
drop	gtt.
teaspoon	tsp. or t.
tablespoon	tbsp. or T.
unit	U.
milliequivalent	mEq.

V - TECS 63
L.A. #2

All Entries Must Be Printed

Medication Administration Record

Enter Here IN PENCIL Number of Forms in Use: 1

Name

Case No.

Room No.

Diagnosis: D.U.B.

Surgery: 11-1-82 VAGINAL Hysterectomy AND - Resuturing VAGINAL Cuff.

Allergic Test (Record in Red): Penicillin

(Use Red Ink)

DATES GIVEN

Form No. 309

Ord. Date Initials	Exp. Date Time	Medication—Dosage—Rt. of Adm.	HR.	10/31	11/1	11/2	11/3	11/4	11/5	11/6	11/7	11/8	11/9	11/10	11/12	11/13
10/31		~~ReFlex - 500 mg P.O q.i.d~~	9													
JC			1					Stop- date								
			5	Jc					Initial name/title.							
			9	J.C												
		Post-OP														
11/1		REFLIN- gms ÷ I.V	4			③Jc	⑦Jc									
		Piggyback q̄. 6 hrs	10			④Jc	⑧Jc					D/c.	p̄	10	P.m	Dose
		X 8 doses	4		①Jc	⑤Jc							11/	3/	82	
			10		②Jc	⑥Jc										
11/2	T	Dalmane - 30mg - P.O	9													
		P.R.N - SLEEP														
11/2		Sliding Scale A.C. AND	7³⁰				Jc									
		Give Regular INSULIN S.Q	Dose				0									
		According to Blood Sugar levels	11 30			J.c	[illegible]									
		As Follows	Dose			[illegible]	Jc									
		400-500 mg % - 20 units S.Q	4 30			Jc	JC									
		300-400mg % - 15 units S.Q.	Dose			[illegible]	[illegible]									
		100-200mg-% - NO INSULIN	9													
			Dose													

(Use Pencil)

SINGLE ORDERS – PRE-OPERATIVES

Enter here in pencil No. of Forms in use

Ord. Date Initials	Rx Medication—Dosage—Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial	Ord. Date Initials	Rx Medication—Dosage—Frequency—Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial
11/1	Dalmane - 30mg P.O	11/1	9	J.C.	11/2	Demerol - 50mg			
	Demerol - 50mg					Vistaril - 50mg } I.M	11/2	7A.m	J.C
	Vistaril - 50mg } I.M	11/1	8 30			Atropine - 0.4mg			
	Atropine - 0.4 mg					Post-OP 11-2-82			
	Post-O.P. DAte ←	(Use Red Ink)							

(PRN ORDERS – SEE REVERSE SIDE)

Doctor: KNOW
Intern:
Date/Time Admitted: 10-31-82 - 3 30 P.m
Age: 35
Religion: BAPTIST
Date/Time Discharged:
Name: Smith - Nancy

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V - TECS 63
L.A. #2

SIGNATURE	TITLE	SIGNATURE	TITLE

PRN Medications

Nurse giving a PRN medication enters, next to the medication, vertically, the date – time given and initials for each dose given.

Post op - Date

Stop Surg - Date

(Use Red Ink)

Or Date Initials	Exp. Date Time	Medication — Dosage — Frequency Rt of Adm.	DOSES GIVEN	
10/31	11/4	~~Demerol - 75-100 mg - IM~~	10/30	10/31
JC		~~q 3-4 hrs~~	10am	[illegible]
		~~PRN - Pain~~	3/30	JC
11/1 JC	4	Vistaril - 50 mg - IM		
		q - 4 hrs		
		PRN - Nausea		
11/1		Percodan i P.O		
		q - 4 hrs		
		PRN - Pain		

341 — 354

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V - TECS 63
L. A. #3

PHYSICIAN'S ORDERS

AUTOMATIC STOP ORDER: SCHEDULE OF STOP DATES REPRODUCED BELOW IS IN TERMS OF DAYS FOLLOWING DATE OF ORIGINAL ORDER. IF STOP DATE FALLS ON SUNDAY OR HOLIDAY ORDER EXTENDED ONE DAY. TIME 11:00 A.M.
THIS ORDER DOES NOT APPLY WHEN PHYSICIAN'S ORDER INDICATES EXACT NUMBER OF DOSES AND/OR DAYS TO BE ADMINISTERED.

ANTIBIOTICS 7
SCHEDULE III MEDICATIONS 7
SCHEDULE II MEDICATIONS 3

DO NOT WRITE IN THIS SECTION IF RED ◆

(✓) START → HERE | DATE 10-31-82 | TIME A.M. P.M. | ALLERGIES: | (1)

Keflex 500 mgm P.O q.i.D
Demerol 75-100 mgm I.M
q- 3-4 hrs P.R.N - Pain
Pre. OP
N.P.O p̄ M.N.
Dalmane 30 mgm P.O - H.S.
Demerol 50 mgm
Vistaril 50 mgm } Im. @ 8^{30} A.M.
Atropine 0.4 mgm.

_______________ M.D. (DISPENSE AS WRITTEN) _______________ M.D. (SUBSTITUTION PERMITTED)

(ADDRESSOGRAPH)

DO NOT WRITE IN THIS SECTION IF RED ◆

(✓) START → HERE | DATE 11-2-82 | TIME A.M. P.M. | ALLERGIES: | (2)

/ Post-OP
Keflin Gm i I.V piggyback q 6 hrs
X 8 doses.
Dalmane 30 mgm P.R.N. P.O @ H.S.
Sliding Scale AC and give Regular Insulin Sq
According to Blood Sugar Level as follow
400-500 mg % - 20 Units Sq
300-400 mgm % - 15 Unit Sq
200-300 mgm % 10 Unit Sq.
100-200 mgm % No insulin

_______________ M.D. (DISPENSE AS WRITTEN) _______________ M.D. (SUBSTITUTION PERMITTED)

(ADDRESSOGRAPH)

DO NOT WRITE IN THIS SECTION IF RED ◆

(✓) START → HERE | DATE 11-2-83 | TIME A.M. P.M. | ALLERGIES: | (3)

Vistaril 50 mgm I.M
q 4 hrs P.R.N - Nausea
Percodan i P.O
q. 4 hrs. P.R.N Pain
Pre. OP
Demerol 50 mgm
Vistaril 50 mgm } I.M
Atropine 0.4 mg

_______________ M.D. 342 ~~355~~ (DISPENSE AS WRITTEN) _______________ M.D. (SUBSTITUTION PERMITTED)

(ADDRESSOGRAPH)

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V - TECS 63
L.A. #5

5'-amp.

REQUEST FOR I.V. MEDICATIONS

(Notify Pharmacy of Cancellation, Ext. 5350)

ADDITIVES	QUANTITY
[✓ Ampicillin]	500 Gm
Carbenicillin (Geopen)	Gm
Cephalothin (Keflin)	Gm
Cephazolin (Kefzol)	Gm
Doxycycline (Vibramycin)	mg.
Gentamycin (Garamycin)	mg.
Hydrocortisone (Solu-Cortef)	mg.
Potassium Chloride	mEq.
Potassium Penicillin G	units

DATE: 10/21/82 Original Solution Number (REFILL NOS. ON BACK)

ORDERED BY: Your Name, Title.

(PATIENT ADDRESSOGRAPH)

CIRCLE SOLUTION	CIRCLE VOLUME	CIRCLE HOURS OF ADMINISTRATION	
		STAT	
[✓ D5W]	[✓ 1000 cc]	01-A.M.	13-P.M.
NS		02-A.M.	14-P.M.
D5NS	500 cc	03-A.M.	15-P.M.
		[✓ 04-A.M.]	[✓ 16-P.M.]
Ringers Lactate		05-A.M.	17-P.M.
	250 cc	06-A.M.	18-P.M.
		07-A.M.	19-P.M.
D5 · ½ NS		08-A.M.	20-P.M.
D5 · ¼ NS	100 cc	09-A.M.	21-P.M.
½ · NS		[✓ 10-A.M.]	[✓ 22-P.M.]
		11-A.M.	23-P.M.
D5RL	50 cc	12-Noon	24-Midnight

VERIFICATION COPY

V - TECS 63
L.A. #5

REQUEST FOR I.V. MEDICATIONS

(Notify Pharmacy of Cancellation, Ext. 5350)

ADDITIVES	QUANTITY
Ampicillin	Gm
Carbenicillin (Geopen)	Gm
Cephalothin (Keflin)	Gm
Cephazolin (Kefzol)	Gm
Doxycycline (Vibramycin)	mg.
Gentamycin (Garamycin)	mg.
Hydrocortisone (Solu-Cortef)	mg.
Potassium Chloride	mEq.
Potassium Penicillin G	units

DATE:	Original Solution Number (REFILL NOS. ON BACK)
ORDERED BY:	

(PATIENT ADDRESSOGRAPH)

CIRCLE SOLUTION	CIRCLE VOLUME	CIRCLE HOURS OF ADMINISTRATION
D5W NS D5NS Ringers Lactate D5 - ½ NS D5 - ¼ NS ½ - NS D5RL	1000 cc 500 cc 250 cc 100 cc 50 cc	STAT 01-A.M. 13-P.M. 02-A.M. 14-P.M. 03-A.M. 15-P.M. 04-A.M. 16-P.M. 05-A.M. 17-P.M. 06-A.M. 18-P.M. 07-A.M. 19-P.M. 08-A.M. 20-P.M. 09-A.M. 21-P.M. 10-A.M. 22-P.M. 11-A.M. 23-P.M. 12-Noon 24-Midnight

VERIFICATION COPY

V-TECS 63
L.A. #7

STUDENT ____________________

DATE ____________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare and route medication index forms.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing and routing medication index forms ...{or Medication Administration Record}..., the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Secured and prepared a Medication index form ... {or Medication Administration Record}...	( )	( )	( )	( )	( )
2. Filed the floor copy and routed duplicate copy to pharmacy.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Inspect and report expiring narcotic or antibiotic orders

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PERFORMANCE OBJECTIVE

Having access to required information and supplies, and six patients receiving narcotics and six patients receiving antibiotics, inspect the orders for expiration time and flag the charts. No patient will receive drugs without a valid order, and charge nurse must agree in each instance that flag was correctly placed, based on expiration of order. (4)

PERFORMANCE GUIDE*

1. Interpret the doctor's orders, consulting the head nurse if needed.
2. Identify narcotics, antibiotics, anticoagulants, and abuse drugs ordered.
3. Compute time of last dose for each order using the stated hospital policy.
4. Flag the charts with a reorder request or notify charge nurse if order is no longer valid.
5. Make certain that flag is easily visible.

* South Carolina writing team suggests a revised listing. Refer to the following revised performance guide.

S.C. PERFORMANCE GUIDE

1. Stamp physician's orders with "Renew Drug" after checking Medication Administration Record for expiration date.
2. Write name(s) only of narcotics, antibiotics and anticoagulants that have expired.
3. Compute time of last dose for each order, using the stated hospital policy.
4. Flag chart with a "Reorder Drug" request; or notify charge nurse if order is no longer valid.
5. Make certain that flag is easily visible.
6. After renewal order, update Medication Administration Record.

LEARNING ACTIVITIES

1. Listen to resource speaker (M.D.) discuss the medical reasons for strict accuracy in the inspection and reporting of expiring narcotic or antibiotic orders.
2. Investigate and report to the class on the following two topics: (a) identification of at least two references the ward clerk can use to find out more information about drugs; (b) identification of the workers whom the ward clerk might contact for drug information.
3. Read and study the attached sample drug renewal policy.

4. Using the policy studied during learning activity #3 and the six-point S.C. Performance Guide, practice inspecting a typical narcotic order and an antibiotic order. Work in small groups helping fellow classmates interpret the procedure.
5. Perform the task of inspecting six narcotic and six antibiotic orders for renewal requests and flagging the charts. A rating of "fully accomplished" must be achieved as the instructor observes in the simulated hospital setting.

RESOURCES

physician

TOOLS AND EQUIPMENT

renewal stamp
reorder tapes
Medication Administration Record
physician's orders

EVALUATION

Using provided information and materials, the student will monitor six narcotic and six antibiotic orders for renewal requests and flag the charts. No errors are allowed. A rating of "fully accomplished" must be achieved, based on the observations of the instructor.

DRUG RENEWAL PROCEDURE

PURPOSE:

To assist with keeping orders for **expiring** drugs current.

POLICY:

1. Class II drugs expire in 72 hours.
2. All class III, IV and V drugs expire in 7 days. Antibiotic or anticoagulant need not be reordered.
3. Write "renew," "repeat," or "reorder" and the name of the medication.
4. The PM Ward Clerk is responsible for writing the name of each expired medication on the physician's order sheet on the date it expires. Sign your initials and title after writing renewal order.
5. The physician must sign the medication order before it is valid.

GENERAL INSTRUCTIONS:

1. The physician will strike through any order he/she wishes to discontinue.
2. Both AM or PM Ward Clerk will be involved in implementing this procedure.

PROCEDURE:

1. Check the Medication Administration Record (MAR) for drugs which expire on current date.
2. Copy all medication orders which expire on the current date from the MAR onto the physician order sheet. (Write the name of the medication exactly as it is written on the MAR.)
3. Enter the date in appropriate column on the MAR after the physician has signed drug renewal order.
4. Sign your initials and title to the left of the column labeled "Noted by/Time."
5. AM or PM Ward Clerk to carry out the order after the physician has signed it by:
    a. Erasing the expiration date (count the appropriate number of days and put in new expiration date).

b. Discontinue the medication by drawing a line through it if the physician does not want to reorder.

Note: Flag chart with Reorder Drug Tape.

REORDER DRUG

V-TECS 65
L.A. #5

STUDENT____________________________

DATE____________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Inspect and report expiring narcotic or antibiotic orders.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When inspecting and reporting expiring narcotic or antibiotic orders, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Verified the doctor's orders and expiration date of the medication.	( )	( )	( )	( )	( )
2. Flagged the chart with a reorder request or notified charge nurse.	( )	( )	( )	( )	( )
3. Updated Medication Administration Record.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Photocopy chart forms

PERFORMANCE OBJECTIVE

Given access to necessary equipment, materials, and information, make a photocopy of each chart form requested. Copies must be legible and any non-usable copies must be destroyed by shredding or burning. (4)

PERFORMANCE GUIDE

1. Locate forms to be copied. Note: Photocopying certain parts of the chart such as lab and X-ray reports to be sent with the patient to a nursing home is often done at the discretion of the hospital to meet Medicare and Medicaid nursing home requirements, and without which nursing homes cannot accept the patient. Nursing care plans and discharge summary notes may be included. Some hospitals permit only medical records personnel to photocopy chart forms so that a record can be kept of what has been copied and where it has been sent.
2. Consult with charge nurse to determine legality of request.
3. Take forms to copy machine.
4. Follow operating instructions and make one legible copy of each.
5. Tear up and discard illegible copies.
6. Enclose copies in an addressed envelope and seal.
7. Give envelopes to appropriate person.
8. Return original chart forms to chart, noting on same that a copy has been made and where it was sent.

LEARNING ACTIVITIES

1. Listen to resource speaker (e.g., director of medical records department at the local hospital) discuss the ethical and legal reasons for confidentiality of chart forms and strict control of non-usable copies of chart forms.
2. Discuss the responsibilities of the ward clerk in following the procedure for photocopying chart forms. Read aloud the attached sample policy which outlines the procedures to be followed.
3. View several copies of chart forms made on different pieces of equipment. As a class, vote which copies are usable and which are not (and the reason).
4. Discuss efficient methods of destroying non-usable copies.
5. Perform the task of photocopying chart forms. Properly destroy non-usable copies. Properly package the copies. A rating of "fully accomplished" must be achieved based on the instructor's evaluation of the performance.

RESOURCES

director of medical records

TOOLS AND EQUIPMENT

copier
chart forms

EVALUATION

Using materials and equipment provided, the student will photocopy selected chart forms. The copies must be clean and legible. Non-usable copies must be completely destroyed. Based on the instructor's observations, a rating of "fully accomplished" must be achieved.

V-TECS 68
L.A. #2

TO: Ward Clerks
Unit Managers
Evening Administrators

FROM: Ward Clerk Coordinator

DATE: July 19, 1983

SUBJECT: Copying a Patient's Chart

1. A Doctor's order must be written on the Physician's Order Sheet in the chart.

2. Have "Authorization for Release Medical Information" signed by the patient prior to copying.

3. Duplication of any part of the patient's chart is done by the Medical Records Department up until 9:00 PM Monday through Friday.

4. Contact the P.M. Administrator or Night Nursing Supervisor when Medical Records is closed.

5. No original part of the patient's chart can be discarded under any circumstance.

6. The Physician should write an order for the parts of the chart to copy.

7. Chart forms that necessarily would not have to be copied (unless the Physician requests specifically) would be the graphics, nurse's notes, profile, and surgery forms.

V-TECS 68
L.A. #5

STUDENT____________________

DATE____________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Photocopy chart forms.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When photocopying chart forms, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Verified legality of request.	( )	( )	( )	( )	( )
2. Copied chart forms.	( )	( )	( )	( )	( )
3. Properly discarded illegible copies.	( )	( )	( )	( )	( )
4. Enclosed and sealed copies in envelope.	( )	( )	( )	( )	( )
5. Provided copies to appropriate person.	( )	( )	( )	( )	( )
6. Noted procedure on chart and returned to proper location.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING CLERICAL ACTIVITIES

TASK: Prepare addressographed nurses' notes sheets for each patient

---

PERFORMANCE OBJECTIVE

Having access to the required materials and information, prepare the nurses' notes form for each of thirty patients. No nurses' notes form will be lost or misplaced. There must be a form for each patient and it must be placed on that patient's clipboard. ...{or chart holders}... . (4)

PERFORMANCE GUIDE

1. Obtain a supply of nurses' notes sheets at beginning of shift.
2. Imprint one sheet for each patient on the unit. Note: If any patient is transferred, discharged, or expires, this sheet becomes a part of the permanent medical record and **must** be taken from the clipboard and routed with the chart.
3. Group the imprinted sheets into team assignments.
4. Place each group of imprinted sheets into each team's clipboard.
5. Place the clipboards in their designated location.
6. Post all of yesterday's completed nurses' notes forms in the patients' charts.

LEARNING ACTIVITIES

1. Distribute sample copies of nurses' notes sheets (attached) and discuss their purpose.
2. Practice imprinting on sheets, using the addressograph.
3. Discuss the procedure to be followed in organizing and placing the sheets. For example, the sheets may be placed in the chart holder under the divider marked "nurses' section" once the previous form is completely filled out. The previous form may remain in the chart holder.
4. Discuss the procedure to be followed if a patient transfers, is discharged, or expires.
5. Visit a unit at the beginning of a shift to observe an experienced ward clerk prepare addressographed nurses' notes sheets for the patients. Under the ward clerk's supervision, practice the preparation of sheets for at least five patients.
6. In a simulated hospital setting, perform the task of preparing addressographed nurses' notes sheets for thirty patients. Place them in the appropriate clipboard chart holder. The performance must warrant a "fully accomplished" rating, based on the instructor's evaluation.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

addressograph
appropriate forms
clipboards or chart holders

EVALUATION

Using provided materials, the student will prepare nurses' notes forms for thirty patients. The appropriate sheet must be placed in that patient's clipboard or chart holder. Based on the instructor's assessment, a rating of "fully accomplished" must be achieved.

V - TECS 69
L.A. #1

INTERDISCIPLINARY PROGRESS NOTES

(ADDRESSOGRAPH)

	Date									
		NIGHT	AM	PM	NIGHT	AM	PM	NIGHT	AM	PM
ACTIVITY	Sleep									
	Bath									
	Ambulation									
	Turn, Cough Deep Breath									
	Dressing Ck.									
	Side Rails Up									
MISCELLANEOUS										

Nurse Assigned 11 - 7			
7 - 3			
3 - 11			

Date & Time	

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ACTIVITY SHEET

DATE ____________________ (ADDRESSOGRAPH)

SHIFT	11-7 A.M.	7-3 P.M.	3-11 P.M.
HY-GIENE			
ACT. SLEEP REST			
SAFETY			
NUTRI-TION			
ELIMI-NATION			
ASSESSMENT			
PSYCHOSOCIAL/PATIENT EDUCATION			
NURSE'S SIGNATURE			

V-TECS 69
L.A. #6

STUDENT ____________________

DATE ____________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare addressographed nurses' notes sheets for each patient.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing addressographed nurses' notes sheets for each patient, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Obtained and prepared the proper form for the number of patients identified.	( )	( )	( )	( )	( )
2. Placed forms in designated location.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Locate assistants for therapists and technicians

PERFORMANCE OBJECTIVE

Given the patient roster, nurse's assignment list, and a therapist needing assistance, locate and notify the assigned person to assist the technician or therapist. Assignment must agree with work organizational plan and capability of worker selected for the task following established policies. (4)

PERFORMANCE GUIDE

1. Identify and greet therapist or technician; ascertain nature of need for assistance.
2. Identify person to whom patient has been assigned (who is responsible for the care of this patient during this tour of duty).
3. Designate assistant to therapists and technicians from patient-care ...(daily duty}... assignment list if possible. Note: Safety of patient, technician, and assistant is of paramount importance.
4. Notify the individual of his/her need to assist technician or therapist by intercom if not in nursing station.
5. Seek assistance of nurse in charge or locate another assistant if assigned person is unable to perform request for some reason.

LEARNING ACTIVITIES

1. Review pertinent points from Lesson 1, V-TECS OBJ. 6: "Greet and direct professionals, new patients, and visitors to patient location."
2. Display on transparency a sample "Daily Unit Assignment Sheet" (attached) and discuss its purpose.
3. Review pertinent points from Lesson 8, V-TECS OBJ. 8: "Initiate and respond to telecom/intercom commnunications."
4. Discuss the reason (need) for seeking assistance of charge nurse if unable to locate assigned person.
5. Listen to a resource speaker (a charge nurse) describe the ramifications if substitutes rather than assigned personnel are used in time of need. Ask questions as appropriate.
6. In a mock hospital setting, perform the task of locating assistants. A rating of "fully accomplished" must be achieved, based on the observations of the instructor.

RESOURCES

charge nurse

TOOLS AND EQUIPMENT

daily duty assignment sheet
patient roster

EVALUATION

Using daily assignment sheet and information provided, the student will locate and notify assistants for technicians and therapists. Established policy must be addressed. Based on the instructor's observations, a rating of "fully accomplished" must be achieved.

DAILY UNIT ASSIGNMENT SHEET

This sheet will be posted on the bulletin board on the unit.

It will be made for each of the three (3) shifts daily.

DATE: Present

CHARGE NURSE or NURSE CLINICIAN will make out this sheet.

UNIT DIVIDED: Nurses and assistants from room numbers to room numbers.

LEARN: Intercom-answer to care for patient's need(s). Be sure to know the patient's room number, name and the need(s) - then tell appropriate person assigned to the patient to take care of the need(s).

Telephone: on the unit -- identify unit, self and title.

V - TECS 46
L.A. #2

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Date

DAILY UNIT ASSIGNMENT SHEET

Shift

Charge Nurse
Break:
Meal:

Ward Clerk
Break:
Meal:

Group I
Rooms

Leader:
Meeting:
Break:
Meal:

Member:
Meeting:
Break:
Meal:
Duty:

Member:
Meeting:
Break:
Meal:
Duty:

Member:
Meeting:
Break:
Meal:
Duty:

Nursing Rounds Time:
Nursing Care Planning Conference:
Time: Patient:
Topic:

Participants:
Suggestions:

Group II
Rooms

Leader:
Meeting:
Break:
Meal:

Member:
Meeting:
Break:
Meal:
Duty:

Member:
Meeting:
Break:
Meal:
Duty:

Member:
Meeting:
Break:
Meal:
Duty:

Nursing Rounds Time:
Nursing Care Planning Conference:
Time: Patient:
Topic:

Participants:
Suggestions:

Form N4(1)-2 4/74

V-TECS 13
L.A. #6

STUDENT______________________________

DATE________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Locate assistants for therapists and technicians.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When locating assistants for therapists and technicians, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Located and notified appropriate assistants for technicians and therapists.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Brief oncoming ward clerk

PERFORMANCE OBJECTIVE

Given an audiotape recorder and access to required information, prepare and present a briefing for an oncoming ward clerk. All items on the instructor's checklist must be rated "fully accomplished." (4)

PERFORMANCE GUIDE

1. Recognize and make brief notes (for yourself) of all happenings (facts, not rumors) which need to be reported to oncoming shift: Accidents, incidents, unusual happenings, new directives, anticipated admissions or discharges, special requests, difficulties, location of patients or charts if not on unit, etc.
2. Obtain tape recorder and blank cassette.
3. From your notes, record all pertinent information using appropriate terminology and diction.
4. Play back to confirm accuracy.
5. Prepare tape and give to oncoming clerk. Note: This report is often given orally in person rather than taped.

LEARNING ACTIVITIES

1. Listen to a resource speaker (an experienced ward clerk) discuss the topic: The role of the ward clerk on the nursing unit can be called that of a **facilitator**.
2. As homework assignment, list the happenings which should be reported to an oncoming shift. Share with classmates. As an entire class, arrive at a consensus listing regarding the happenings which warrant being reported.
3. Read aloud in small groups samples of daily summary sheets. Decide which facts need to be reportd (and cite reasons).
4. Visit a unit and "shadow" an experienced ward clerk throughout a shift.
5. With the supervision of the ward clerk who participated during learning activity #4, perform the task of briefing the oncoming ward clerk. Use an audiotape recorder and speak concisely, clearly, and accurately. The instructor with the aid of the ward clerk will evaluate your performance. A rating of "fully accomplished" must be achieved on each item listed on the instructor's checklist.

RESOURCES

exerienced ward clerk

TOOLS AND EQUIPMENT

audiotape recorder
cassette

EVALUATION

Using the standard policies, daily summary notes, and tape recorder, the student will brief an oncoming ward clerk. All items on the instructor's checklist must be rated "fully accomplished."

V-TECS 14
L.A. #5

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Brief oncoming ward clerk.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When briefing oncoming ward clerk, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Segregated fact from rumor by documented evidence.	( )	( )	( )	( )	( )
2. Protected confidentiality of information.	( )	( )	( )	( )	( )
3. Used appropriate terminology, grammar, diction, and tone of voice.	( )	( )	( )	( )	( )
4. Included all pertinent information.	( )	( )	( )	( )	( )
5. Relayed messages accurately in understandable terms.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Dispense and charge supplies

PERFORMANCE OBJECTIVE

Having access to required information and supplies, and given a request for a catheter irrigation set, dispense the item, prepare charge form and adjust the inventory without error. Item dispensed must be acceptable to the requesting person, charge form must identify the correct patient and item, and inventory must reflect the correct number of items remaining. (4)

PERFORMANCE GUIDE

1. Acknowledge request.
2. Fill out charge form and stamp with correct addressograph plate. Note: Carbon sets require ball-point pen and heavy writing pressure.
3. Send stamped form to correct department or place information in computer.
4. Check and dispense items, adjust inventory if applicable.
5. Place items in designated area, or give to the person requesting the article.
6. Report problems or substitutions to charge nurse.
7. Identify from Kardex or other records all "daily" charges for cots, traction, isolation, narcotics, etc., and prepare charges in above manner.
8. Dispense desk supplies to appropriate locations: labels, chart flags, note pads, PRN sheets, writing implements for acceptable charting, chart forms, requisition forms, supplemental chart forms, prescription blanks, etc.

LEARNING ACTIVITIES

1. Discuss the way to verify request made on the physician's order or directly from a person.
2. Visit a unit to observe where supplies are kept. Note that each supply item should have charge form attached.
3. Demonstrate method for completing charge form. Note: If no charge form is attached to supply item, learn where forms are kept. Some items have charge sticker attached which merely requires being placed on charge form.
4. Discuss the departments and their function regarding who must receive charge forms.
5. Outline on board the tasks involved in acquiring an item. For example: Once form is stamped, nursing assistant goes to appropriate department to acquire if not kept on unit. Then the item is given to requestor. If exchange cart system is used, the requestor must remove from cart and give charge sticker to ward clerk or other designated personnel. For example, the ward clerks

may make a list of supplies needed and at the overlap of AM & PM Shift (while two ward clerks are present), one goes to the print shop and picks up supplies, returns to unit, and places in appropriate location.

6. Visit the department which keeps dispensable items. Inquire about the procedure to be followed in acquiring them.
7. Visit a unit to observe an experienced ward clerk dispense a supply item, charge it, and adjust the inventory. Take detailed notes to be studied and used later as reference.
8. In a mock hospital setting, perform the task of dispensing a catheter irrigation set, charging it, and adjusting the inventory. A rating of "fully accomplished" must be achieved, based on the instructor's evaluation.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

charge slips
catheter irrigation set
ball point pen
inventory list
addressograph

EVALUATION

Using the materials and information provided, the student will dispense a catheter irrigation set, charge it, and adjust the inventory. Accuracy must be 100%. A rating of "fully accomplished" must be achieved, based on the assessment of the instructor.

V - TECS 15
L. A. #3

LIFT HERE QTY: 142-7529 •ST ADMIN SET IVA C PED CONTROL LER 76010	SAMPLE 2	3	Stamp with the patient's charge plate. Each item on the Sterile Processing Cart will have a stamp. The stamp will be removed as the items are used and placed on the charge card. At the end of each shift, the card is sent to the Sterile Processing Dept. and charged to the patient.	
4	5	6		
7	8	9	10	SPD

Room #	Bed #	Patient	Date	Other	Quan.	Code

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STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Dispense and charge supplies.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When dispensing and charging supplies, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Dispensed a catheter irrigation set, prepared charge and adjusted the inventory.	( )	( )	( )	( )	( )
2. Identified from records all daily charges; prepared forms.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Check and route patient food trays

PERFORMANCE OBJECTIVE

Given the diet worksheet, the patients' trays with tray cards, check and route patient food trays without undue delay. No person will receive the wrong diet in accordance with source data as judged by the instructor, and food trays will be routed within fifteen minutes.

PERFORMANCE GUIDE

1. Check ordered diet with diet card on tray. Note: The dietitian checks the food allowed on each diet in the kitchen. The ward clerk checks the diet card against the diet worksheet, sees that aide takes the tray to the correct patient. Non-English speaking aides need this assistance particularly.
2. Determine that all diets ordered were delivered to unit.
3. Check the physical appearance of the tray.
4. Oversee delivery of food tray to correct patient in correct room as quickly as possible.
5. Determine that all patients who were to receive trays were served.
6. Notify dietary department of any discrepancies.
7. Notify dietitian to visit food-problem patients.
8. In emergency situation, serve food tray.

LEARNING ACTIVITIES

1. Visit the dietary department and observe the tasks performed by the kitchen personnel. (If tour has already occurred, review original findings with classmates.)
2. Identify by position the dietary staff with whom the ward clerk works.
3. Discuss pertinent points from Lesson 17, V-TECS OBJ. 41; "Institute/change/discontinue diet service (e.g., location that dietary requisition is posted).
4. Review the procedure of the local health care facility for verifying patient's diet (e.g., check patient care form).
5. Role play notifying nursing assistant/nursing technician responsible for patient that tray is available for transporting to patient.
6. Role play conversation about meals which may be initiated by patient toward ward clerk. Critique each other's performance.
7. Review proper telephone procedure to be followed when calling dietary department about discrepancies or need for dietitian. (i.e., Give name, title, unit, patient's name, room number, and request.)
8. Discuss the duties of the ward clerk pertaining to menus (e.g., filling in the names of the patients and room numbers).
9. Investigate and define the ward clerk's responsibilities regarding

stock nourishments.

10. Visit a unit to observe an experienced ward clerk as he/she checks and routes patient food trays, notifies dietary department of any discrepancies, notifies dietitian to study good-problem patients. Ask questions and assist when asked.
11. Under the supervision of an experienced ward clerk, perform the task of checking and routing patient food trays. A rating of "fully accomplished" must be achieved, based on the instructor's evaluation of the accuracy and expediency with which the task is performed.

RESOURCES

experienced ward clerk
dietary personnel

TOOLS AND EQUIPMENT

diet worksheet
patient food trays

EVALUATION

Using materials provided, the student will check and route patient food trays. The diets must correspond with the patient and the routing must occur within fifteen minutes. A rating of "fully accomplished" must be achieved, based on the instructor's observations.

DIETARY DIET ORDER REQUISITION

CARBON NOT REQUIRED

BY: ______________________________ R N

A.M.: 4:30

FLOOR: ______________________________

V - TECS 16
L. A. #11

CALL TIME – D&S

DATE: ______________________________

9:30 A.M. & 12:30 P.M.

ROOM NO.	NAME	HOLD, ECT.	FULL (REGULAR)	SOFT	LIQUIDS		SPECIAL DIETS	DINNER CHECK	SUPPER CHECK
					SURG	FULL			

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Reynolds+Reynolds CELINA OHIO LITHO IN U.S.A.

V-TECS 16
L.A. #11

STUDENT____________________________

DATE_______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Check and route patient food trays.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When checking and routing patient food trays, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Checked and routed patient's food tray.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Initiate codes upon nurses' directives

PERFORMANCE OBJECTIVE

Given the necessary equipment and a hypothetical situation, initiate a code alert. Code used must match posted procedure. (4)

PERFORMANCE GUIDE

1. Receive accurate code requests.
2. Call the telephone operator to page the code alert or dial the specified number and page the code alert.
3. Provide accurate location and type of code (cardiac arrest, medical emergency, fire, etc.).
4. Take your assigned position at the telephone.
5. Send the crash cart to the location via other unit personnel.
6. Monitor the intercom to assure speed in responding to other directives.
7. Make all calls as directed, keeping open at least one incoming line.
8. Reassure the other patients as they become aware of the problem.

LEARNING ACTIVITIES

1. Distribute information sheet titled "Ward Clerk Responsibilities during Emergency Codes"; discuss each item.
2. Investigate and prepare a chart outlining the emergency codes in the local hospital along with explanations of the responsibilities of the ward clerk.
3. Dramatize (with classmates) a medical emergency: a cardiac arrest. Role play the staff personnel who are usually assigned to a cardiac team. Demonstrate the ward clerk's responsibilities, including dealings with a family or visitors who are present.
4. Interview an experienced ward clerk who has initiated a code alert. Orally recite the procedure which he/she followed. Include any mistakes which might have been inadvertently made.
5. Research hospital policies, etc., and write a report which addresses the following four questions: a) What purpose is served by the fire alarm code? b) When the fire alarm goes off, who receives the signal? c) Why must personnel throughout the hospital be made aware of a fire occurring **anywhere** in the hospital? d) In cases of fire, what is the first responsibility of every member of the staff?
6. Observe a demonstration of the use of fire-fighting equipment in the local hospital.
7. List the fire regulations in the local hospital.
8. Observe a demonstration of the operation of emergency equipment such as the defibrillator.
9. Discuss the function of the crash cart.
10. Discuss the importance of leaving one incoming line "clear" during an emergency.

11. In a simulated situation, perform the task of initiating an emergency alert. List all steps of the procedures to initiate coded alerts for cardiac arrest, medical emergencies such as hemorrhage, fire, explosion, and disaster. A rating of "fully accomplished" must be achieved, based on the instructor's evaluation.

RESOURCES

fire fighting team
experienced ward clerk

TOOLS AND EQUIPMENT

code plans

EVALUATION

Using provided information, the student will 1) initiate an emergency alert as directed in a simulated situation. Also the student will 2) list all steps of the procedures to initiate coded alerts for cardiac arrest, medical emergencies such as anaphylactic shock hemorrhage, fire, explosion, and disaster. Both performances must earn a rating of "fully accomplished," based on the assessment of the instructor.

WARD CLERK RESPONSIBILITIES DURING EMERGENCY CODES

1. Remain calm in all emergency situations and know how to get help.
2. Stay at the desk by the phone to monitor calls, make calls, take and relay messages.
3. If the unit is ordered to evacuate, remove patient's charts, medications and nursing care notebook to safety.
4. Your Nurse Clinician, his/her designees, or your Unit Manager, will inform you when to page.

MAY DAYS

1. Telephone - dial ext. #5000, identify yourself, and your unit and room #, and ask the operator to page "Doctor May Day." If a busy signal, call switchboard operator.
2. Be visible in hallway to direct the mayday team to the appropriate room and bed #.
3. Stay at the desk by the telephone to assist with making and relaying messages.
4. Perform all Ward Clerk responsibilities as ordered.

CODE RED

1. Call the switchboard operator, identify self and unit, give operator the type and location of fire.
2. Know where fire extinguishers and hoses are located on the unit.
3. Stay at the desk by the telephone to make or relay any messages.
4. Perform all Ward Clerk responsibilities as ordered.
5. If your unit is ordered to evacuate, take patient's charts, medications, and nursing care notebook to safety.

CODE BLUE

1. Stand by when Code Blue is announced by the switchboard operator.
2. Assist nurse with preparing a list of available beds and room numbers.

3. Assist nurse with preparing a list of patient's names, room and bed numbers, that could be discharged or transferred to another unit.

4. Send both lists to the admitting office at once.

5. Perform all other Ward Clerk responsibilities.

CODE YELLOW

1. Stand by when announced by the switchboard operator.

2. Perform all Ward Clerk responsibilities.

V-TECS 17
L.A. #11

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Initiate codes upon nurses' directives.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When initiating codes upon nurses' directives, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Assumed assigned position at the telephone and made calls as directed.	( )	( )	( )	( )	( )
2. Assumed assigned position at the telephone and made calls as directed.	( )	( )	( )	( )	( )
3. Reassured the other patients as necessary.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Initiate and route incident or accident reports

PERFORMANCE OBJECTIVE

Given access to the forms and information needed concerning an accident and an incident in which a ward clerk was involved, prepare and route the accident and incident forms without error as to time, place, and identity. (4)

PERFORMANCE GUIDE

1. Notify supervisor of incident or accident.
2. Secure the incident/accident form which, when completed, becomes a legal document.
3. Place names, date, time, and place on the form in the proper location.
4. Write a brief account of what happened. Caution: Strict adherence to accurate fact is vitally important since this report constitutes a part of a possible litigation process.
5. Put form in designated place for the proper person to complete.
6. Have form signed by physician when completely filled out.
7. Send the completed report form to the nursing office.

LEARNING ACTIVITIES

1. Discuss the definition of an "incident" and cite examples.
2. List people who may be involved in incidents.
3. Discuss the reasons an incident report must be filled out.
4. Outline the procedure for completing an incident report.
5. Visit a unit to learn where incident reports are filed. Inquire how long such forms are kept.
6. Investigate the regulations used in the local hospital for reporting incidents.
7. Distribute and discuss the attached sample incident report. Discuss each section thoroughly.
8. Role play a typical incident situation: Someone is an "accident victim" and the "ward clerk" is dealing with the incident. The "ward clerk" will demonstrate filling out the report forms for the class (using overhead transparencies). The class will check the results for completeness and accuracy.
9. Distribute the attached sample employee accident report. Discuss each section thoroughly.
10. Perform the task of preparing and routing one accident and one incident report, based on a hypothetical situation provided by the instructor. A rating of "fully accomplished" must be achieved.

TOOLS AND EQUIPMENT

appropriate forms

EVALUATION

Using the forms and information provided, the student will prepare and route one accident report and one incident report. The hypothetical situation will be observed and rated by the instructor. A rating of "fully accomplished" must be achieved.

☐ CHECK IF INCIDENT OCCURRED IN LONG TERM OR NURSING HOME FACILITY.

CONFIDENTIAL HOSPITAL INCIDENT REPORT
PROPERTY OF HOSPITAL ATTORNEY

V - TECS 18
L.A. #7

NAME OF PATIENT OR VISITOR
ADDRESS
ATTENDING PHYSICIAN
DIAGNOSIS PRIOR TO INCIDENT
IF SURGERY, DATE AND TYPE

SECTION I – COMPLETE THIS SECTION FOR ALL INCIDENTS

HOSPITAL
CITY

DATE OF INCIDENT
TIME
1 A.M. 2 P.M.
1 PATIENT 2 VISITOR
ROOM NO
AGE YRS MOS
1 MALE 2 FEMALE

LOCATION OF INCIDENT

1 PATIENT'S ROOM
2 NURSES STATION
3 BATHROOM
4 CORRIDOR
5 DIETARY
6 RECOVERY ROOM
7 LABORATORY
8 PHYSICAL THERAPY
9 X RAY
10 LABOR/DELIVERY
11 OUTPATIENT
12 PHARMACY
13 ICU
14 PARKING LOT/WALK
16 OPERATING ROOM
17 EMERGENCY ROOM
18 CCU
19 RESPIRATORY THER.
20 NUCLEAR MEDICINE
21 LOBBY
22 DINING RM/CAFETERIA
23 DAYROOM
24 NURSERY
15 OTHER

		CODE			
1	8			27	34
2	9	15	21	28	35
3	10	16	22	29	36
4	11	17	23	30	37
5	12	18	24	31	38
6	13	19	25	32	39
7	14	20	26	33	40

APPARENT REASON FOR INCIDENT

1 WET OR FOREIGN MATTER ON FLOOR
2 CLIMBED OVER SIDERAILS
3 REACHING
4 FOOTWEAR
5 BRAKES, SIDERAILS OR SAFETY EQUIPMENT NOT USED
6 WEAKNESS, SEIZURE, FAINTING, LOSS OF BALANCE
7 DEFECTIVE EQUIPMENT
8 PATIENT IDENTIFICATION NOT CHECKED
9 TRANSCRIBED ORDER INCORRECTLY
10 MEDICATION OR IV DOSAGE NOT CORRECT
11 WRONG MEDICATION FROM PHARMACY
12 PHYSICIAN'S ORDER NOT CLEAR
13 UNCLEAR OR DUPLICATION OF ASSIGNMENT
14 PHYSICIAN'S ORDERS NOT CHECKED OR OVERLOOKED
15 MEDICATION CARD MIX UP
16 DELAYED CHARTING
17 UNFAMILIAR TREATMENT OR PROCEDURE
18 MISREAD MEDICATION LABEL
19 OTHER EXPLAIN

RESULT OF INCIDENT INJURY

1 NO APPARENT INJURY
2 MINOR INJURY NO RESIDUAL EFFECT EXPECTED BEYOND 12 HOURS
3 SERIOUS RESIDUAL EFFECT EXPECTED BEYOND 12 HOURS BUT NO PERMANENT INJURY
4 GRAVE PERMANENT INJURY

CONDITION PRIOR TO INCIDENT

1 ALERT – ORIENTED
2 SEDATED/MEDICATED
INDICATE MEDICATION
INDICATE TIME OF LAST MEDICATION
3 SENILE
4 UNCONSCIOUS
5 DISORIENTED
6 OTHER EXPLAIN

PATIENT OR VISITOR ATTITUDE AFTER INCIDENT

1 NOT AWARE OF INCIDENT
2 COOPERATIVE
3 UNCOOPERATIVE
4 ANGRY

SECTION II – COMPLETE THIS SECTION FOR ALL FALL INCIDENTS

FALL INVOLVED

1 BED
BEDRAILS WERE
1 UP 2 DOWN 3 ABSENT
BED POSITION
1 HIGH 2 LOW 3 NOT ADJ.
BEDRAIL LENGTH
1 1/2 2 3/4 3 FULL
2 CHAIR
3 WHEELCHAIR
4 STRETCHER
5 TABLE
6 TUB OR SHOWER
7 TOILET
8 FOOTSTOOL
9 TO OR FROM BATHROOM

RESTRAINTS USED?
1 YES 2 NO

PHYSICIAN'S ORDERS PRIOR TO INCIDENT

1 RESTRAINTS
2 COMPLETE BEDREST
3 BATHROOM PRIVILEGES
4 UP WITH AID
5 UNLIMITED ACTIVITY

SECTION III – COMPLETE THIS SECTION FOR MEDICATION, TREATMENT

1 WRONG MEDICATION, TREATMENT, PROCEDURE, DIET
2 WRONG PATIENT
3 WRONG TIME
4 OMISSION
5 WRONG IV
6 INCORRECT DOSAGE OR STRENGTH
7 INCORRECT METHOD OF ADMINISTRATION
8 REACTION
9 RATE OF ADMINISTRATION
10 EQUIPMENT FAILURE
11 INFILTRATION

SECTION IV – COMPLETE THIS SECTION FOR ALL OPERATING ROOM INCIDENTS
SECTION IV – COMPLETE THIS SECTION FOR ALL OUTPATIENT/EMERGENCY INCIDENTS

☐
☐

SECTION V – COMPLETE THIS SECTION FOR ALL INCIDENTS

GIVE BRIEF FACTUAL DESCRIPTION OF INCIDENT AND ACTION TAKEN AFTER INCIDENT (IF MEDICATION ERROR, GIVE NAME AND DOSE OF BOTH CORRECT AND INCORRECT MEDICATION)

NAME OF EMPLOYEE INVOLVED IN INCIDENT 1 RN 2 LPN 3 AIDE 4 STUDENT 5 ORDERLY 6 OTHER
EMPLOYEE WHO DISCOVERED INCIDENT

NAME OF WITNESS ADDRESS
NAME OF WITNESS ADDRESS

PHYSICIAN'S COMMENTS, INCLUDING TREATMENT GIVEN (NAME OF PERSON RECEIVING COMMENTS)

NAME OF EXAMINING PHYSICIAN

SIGNATURE OF PERSON PREPARING REPORT
SIGNATURE OF PERSON REVIEWING REPORT

COMMENTS

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2277

V - TECS 18
L.A. #9

EMPLOYEE ACCIDENT REPORT

This form is to be used for job related accidents only. Use regular incident report form for the reporting of any other hospital incidents.

Social Security No.

Phone No.

Job Title

Sex ☐ M ☐ F

Time of Injury ☐ AM ☐ PM Exact Location of Accident

☐ Unsafe Act ☐ Unsafe Condition | Describe Act/Condition

EXPENSE.

Person making initial report

This Section to be filled in by Employee Health Office or Emergency Room

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V-TECS 18
L.A. #10

STUDENT ______________________________

DATE ______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Initiate and route incident or accident reports.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When initiating and routing incident or accident reports, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Prepared proper accident report form.	( )	( )	( )	( )	( )
2. Prepared proper incident report form.	( )	( )	( )	( )	( )
3. Insured completion of form by proper person.	( )	( )	( )	( )	( )
4. Routed the form to the proper location.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Prepare and route report forms

PERFORMANCE OBJECTIVE

Given the required information representing activity on a nursing unit and a 24-hour report form, prepare and route the form. All pertinent information will be included and accurate in accordance with source data as judged by the instructor, and routing procedure must follow established system for delivering at time specified on the form. (4)

PERFORMANCE GUIDE

1. Obtain the required form.
2. Locate all information needed from census sheet, surgery list, condition sheet, and Kardex cards.
3. Fill in the required information in each column of form, including any special treatments, procedures, or problems on the unit.
4. Give to the charge nurse for her approval and signature.
5. Route to the supervisor, nursing office, or designated department.
6. File the duplicate form.
7. Follow same procedure for infection control forms, utilization reports, and other similar reports.

LEARNING ACTIVITIES

1. Investigate the 24-hour report forms used by three health care facilities. Compare similarities and differences.
2. Discuss the purpose of a 24-hour report form.
3. Outline the pertinent information which should be included by the ward clerk.
4. Using the form supplied by the hospital which is serving as the site for the student's clinical experience and/or employment, demonstrate filling out the form.
5. Write the routing procedure to be followed in regard to the form filled out during learning activity #4.
6. Perform the task of preparing and routing (via verbal description) a 24-hour report. A rating of "fully accomplished" must be earned, based on the instructor's evaluation.

TOOLS AND EQUIPMENT

appropriate forms

EVALUATION

Using the information and materials provided, the student will prepare a 24-hour report form and verbally describe its routing. A rating of "fully accomplished" must be achieved, based on the instructor's observations.

V-TECS 19
L.A. #6

STUDENT____________________________

DATE____________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare and route report forms.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing and routing report forms, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Prepared a 24-hour report form.	( )	( )	( )	( )	( )
2. Secured the signature of charge nurse.	( )	( )	( )	( )	( )
3. Routed the report forms to proper locations.	( )	( )	( )	( )	( )
4. Filed the floor copies.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Arrange maintenance and repair of equipment

PERFORMANCE OBJECTIVE

Given a wheel chair with reported defective brakes, an electric bed which fails to operate, a room which the head nurse deems in need of painting, and a non-functioning drain, make all necessary arrangements to schedule the maintenance and repairs needed. Disruption will be minimum, and equipment will not be lost. (4)

PERFORMANCE GUIDE

1. Notify maintenance department of problem or article needing repair or service.
2. Determine when maintenance can provide the service needed.
3. Consult with head nuurse, housekeeping department, and admission office if needed.
4. Confirm appointment with maintenance department.
5. Fill out needed forms and route, filing the floor copy.
6. Note inventory if applicable.
7. Verify that repairs were done. Note: This will vary depending on the type of article and on the capability of the person returning the article.
8. Sign the work order showing that work was done and item was returned.
9. Place the article in its proper location.
10. Inspect flashlights, otoscopes, stethoscopes and sphygmomanometers and replace parts as needed.
11. Inspect and record refrigerator functioning.
12. Update inventory.

LEARNING ACTIVITIES

1. Visit the plant operations and housekeeping departments of the local hospital to learn their responsibility for the appearance, cleanliness, and upkeep of the hospital.
2. Discuuss the procedure to be followed in arranging major programs (such as replacing draperies, carpets, etc.) vs. the procedure to be followed in arranging routine maintenance and repair.
3. Practice preparing a list for routine maintenance and repair (e.g., a leaky faucet, burned-out light bulb, soiled carpet, broken part on stethoscope).
4. Discuss the purpose of a work order and the ward clerk's signature when work is completed.
5. Discuss relationship of inventory records to maintenance and repair.
6. Perform the task of "arranging maintenance and repair" for evaluation by the instructor. A rating of "fully accomplished" must be earned.

RESOURCES

- plant operations personnel

TOOLS AND EQUIPMENT

appropriate forms

EVALUATION

Using the materials and information supplied, the student will arrange for maintenance and repair of the equipment listed in the performance objective at the top of the preceding page. A rating of "fully accomplished" must be achieved, based on the assessment of the instructor.

V-TECS 20
L.A. #6

STUDENT__________________________

DATE____________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Arrange maintenance and repair of equipment.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When arranging maintenance and repair of equipment, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Arranged for maintenance and repair of the identified equipment.	( )	( )	( )	( )	( )
2. Verified that repairs were done.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Prepare and maintain a Laboratory and X-ray "Hold Diet" sheet

---

PERFORMANCE OBJECTIVE

Given the Kardex and charts for forty patients, procedure manuals, and the "hold diet" sheet, prepare and maintain the lab and X-ray "hold diet" sheet. The results must agree with the instructor's findings and manual used. No patient will be scheduled to receive food which will interfere with diagnostic procedures. (4)

PERFORMANCE GUIDE

1. Obtain the "hold diet" sheet or Master Diagnostic Procedure sheet. Note: See attached sample.
2. Determine from Kardex and charts which patients have diagnostic procedures ordered. Note: Knowledge of terminology and abbreviations essential.
3. Locate designated space on form for each entry.
4. Enter name, room number, procedure, and date to be performed for each ordered test.
5. Use procedure manuals to determine dietary alterations and notify dietary department in routine manner, annotating Kardex ...(or changing diet in-patient care form)... .
6. Place sheet in designated location for technician to sign when patient may have food.
7. Notify dietary department when patient is allowed to have food.
8. Determine that all ordered tests were done. If not, find out why and report to head nurse.
9. File pages in appropriate place as hospital policy dictates.

LEARNING ACTIVITIES

1. Distribute the following attached sample forms and discuss the purpose of each: Diagnostic and Miscellaneous Procedures Form, Schedule for Patient Treatment Form (including policy), and Master Diagnostic Procedure Sheet.
2. Discuss the procedure for completion of each form.
3. Discuss the required procedure for reading the patient care form and chart to decide which patients have diagnostic procedures ordered (i.e., note physician's orders).
4. Study the procedure manual of the local hospital to identify the various dietary alterations and discuss each in class.
5. Review the procedure for notifying dietary department (i.e., call; give name, unit, title, patient's name, room number and diet order).
6. Research, compile, and memorize the terminology and abbreviations essential to diet orders (e.g., N.P.O., clear liquid, bland, lo residue, etc.).
7. Given physician's orders with diagnostic tests ordered, practice completing the appropriate forms.

8. Visit unit to observe where "hold diet" sheets are posted.
9. Observe an experienced ward clerk in the process of preparing entries in the "hold diet" sheet and maintaining the record. Assist if asked.
10. Under the supervision of an experienced ward clerk, perform the task of preparing entries in the "hold diet" sheet and maintaining the record. Charts for forty patients will be provided. A rating of "fully accomplished" must be achieved, based on the evaluation of the instructor and the ward clerk.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms

EVALUATION

Using information and materials provided by the instructor, the student will prepare entries in "hold diet" sheet and maintain the record. Accuracy must be 100%. A rating of "fully accomplished" must be achieved, based on the assessment of the instructor.

V - TECS 21
L.A. #1

(DIAGNOSTIC & MISCELLANEOUS PROCEDURES FORM)

(ADDRESSOGRAPH)

DATE	RN LPN	LAB, EKG, EEG	DATE	NURSE	DATE	RN LPN	X-RAY	DATE	NURSE

DATE	RN LPN	DAILY LAB, X-RAY, ETC	DATE	NURSE	DATE	RN LPN	PHYSICAL THERAPY	DATE	NURSE

DATE	RN LPN	NUCLEAR MEDICINE/ RADIATION THERAPY	DATE	NURSE	DATE	RN LPN	RESPIRATORY THERAPY	DATE	NURSE

8/80

SCHEDULE FOR PATIENT TREATMENT FORM

Definition and Purpose: The schedule for patient treatment form which facilitates communication to nursing personnel regarding schedules for treatment/test by other departments.

Responsible Person: To be completed by the P.M. Unit Secretary.

1. Complete during 3 - 11 shift.
2. Complete the date and unit #.
3. List the patient's room and name in appropriate column.
4. List the department the patient is held N.P.O. for.
5. Write the name of tests/treatment.
6. Will be posted on the bar above the Unit Secretary's desk.
7. Write in chart (yes/no) the time the patient leaves, returned time, and initials of the appropriate person.

Note: When a patient has many tests ordered (Lab) you may skip a space and use the second column so test ordered may be written legibly.

V - TECS 21
L.A. #1

SCHEDULE FOR PATIENT TREATMENT

DATE________________

UNIT________________

DEPARTMENT

Rm #	Patient	NPO	Surg.	Laboratory	EKG	X-ray	Nucl Med.	Cat Scan	P.T.	Time Leaving	Return Time	Chart	Initial	R.R. Time
		Surg												
		X-Ray				Barium Enema								
		LAB		SMA-12										

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V - TECS 21
L.A. #1

MASTER DIAGNOSTIC PROCEDURE SHEET

DATE:________________

X-RAY NPO	ROOM	PATIENT'S NAME	TIME TO X-RAY	TIME RETURNED	DIET RELEASE	COMMENTS

SURGERY ROOM	PATIENT'S NAME	TIME TO SURGERY	RETURNED TO UNIT

ECG ROOM	PATIENT'S NAME	INITIAL & TIME COMPLETED

MISC. NPO	ROOM	PATIENT	TEST	TIME COMPLETED

LAB NPO	ROOM	PATIENT'S NAME	INITIAL	TIME COMPLETED	TEST	DIET RELEASE

V-TECS 21
L.A. #10

STUDENT______________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare and maintain a laboratory and X-ray "Hold Diet" sheet.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing and maintaining a laboratory and X-ray "Hold Diet" sheet, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Obtained proper sheets.	( )	( )	( )	( )	( )
2. Verified diagnostic procedures ordered.	( )	( )	( )	( )	( )
3. Notified dietary department of diet change.	( )	( )	( )	( )	( )
4. Determined that all ordered tests have been done; notified dietary department.	( )	( )	( )	( )	( )
5. Filed sheets in appropriate location.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Prepare a supply of assembled packets for admission, surgery, discharges

---

PERFORMANCE OBJECTIVE

Given access to chart supplies and packet content information, assemble and maintain a supply of packets for admissions, discharges, and surgical procedures. Packets must contain all forms required by using institution and meet at least the next 24-hour unit needs. (4)

PERFORMANCE GUIDE

1. Check reserve form supplies on unit and order more if necessary.
2. Assemble or assign a volunteer to assemble packets from unit supply according to type of packet desired, i.e., admission, surgery, or discharge.
3. Make certain that each packet is complete and contains the proper articles and forms. Many ward clerks also prepare and maintain a supply of assembled items called an "admission pack." This generally consists of items for which the patient is charged such as disposable bed pan, face basin, emesis basin, soap dish, soap, toothbrush, toothpaste, back-rub lotion, comb, etc.
4. Place assembled packets in area designated.

LEARNING ACTIVITIES

1. Visit a unit to learn where supplies are kept.
2. Discuss materials needed for each type of packet to be assembled (attached). Display samples of forms included in each assembled packet.
3. Work under the direction of an experienced ward clerk in assembling three packets (one each for admission, surgery and discharge). Note that most health care facilities purchase preassembled "admission packs" (i.e., soap, toothbrush, etc.).
4. Visit area in local hospital that is designated for storage of assembled packets.
5. Given materials, perform the task of assembling an adequate supply of packets for admissions, discharges and surgical procedures. A rating of "fully accomplished" must be achieved, based on the evaluation of the instructor and an experienced ward clerk.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms

EVALUATION

Using materials provided, the student will assemble and maintain a supply of packets for admissions, discharges and surgical procedures. The packets must be complete. A rating of "fully accomplished" must be achieved, based on the instructor's assessment.

V-TECS 22
L.A. #2

The newly admitted patient's chart consists of the following eight forms. Stamp these forms with the name plate when admitting the patient.

Chart Forms

1.	Graphic Sheet/Intake-Output Record	
2.	Physician's Orders	Physician's orders
3.	Progress Notes	Medical
4.	Hematology Laboratory Reports (C.B.C.)	Diagnostic
5.	Chemistry (S.M.A. Mount Sheet)	Diagnostic
6.	Miscellaneous Lab Mount Sheet	Diagnostic
7.	Profile (Patient History and Nursing Observation)	Nurse's Section
8.	Interdisciplinary Progress Notes	Nurse's Section
		Miscellaneous

V-TECS 22
L.A. #2

ADMITTING CHART - PSYCHIATRIC WARD

The newly admitted patient's chart consists of the following eleven forms. Stamp these forms with the name plate when admitting the patient.

Chart Forms

1.	Graphic Sheet/Intake-Output Record	
2.	Physician's Orders	Physician's Orders
3.	Progress Notes	Medical
4.	Affiliated professional staff	Medical
5.	History and Physical	Medical
6.	Hematology Laboratory Reports (C.B.C)	Diagnostic
7.	Chemistry (S.M.A. Mount Sheet)	Diagnostic
8.	Miscellaneous Lab Mount Sheet	Diagnostic
9.	Psychiatric Patient Assessment Sheet	Nurse's Section
10.	Interdisciplinary Progress Notes	Nurse's Section
11.	Occupational Therapy Referral Psychiatric Service	Miscellaneous

Stamp these five forms with the patient's name plate and place on the front of the chart when a patient goes to surgery.

1. Consent to Operation, Anesthetic and other Medical Services
2. Frequent Observation Record
3. Anesthesia Record
4. Pre-operative Checklist
5. Fluid Administration Form

V-TECS 22
L.A. #5

STUDENT____________________________

DATE_______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare a supply of assembled packets for admission, surgery, discharges.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing a supply of assembled packets for admission, surgery, discharges, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Assembled a packet for:					
a. admission	( )	( )	( )	( )	( )
b. surgery	( )	( )	( )	( )	( )
c. discharge	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Maintain inventories of supplies and equipment

PERFORMANCE OBJECTIVE

Given an inventory of supplies and equipment for a nursing unit, with a specified minimum and maximum standard, maintain the inventory. Inventories will reflect supplies on hand within the specified minimum and maximum levels of standard at any given time and agree with the actual count of items present for at least any four out of five items. (4)

PERFORMANCE GUIDE

1. Obtain supply and equipment inventory file. Note: This will include wheelchairs, stretchers, and unit library resources.
2. Identify floor standard, using appropriate name or computer number of article.
3. Add supplies and equipment received to existing inventory.
4. Subtract supplies and equipment dispensed from existing inventory.
5. Check existing supplies and equipment against inventory file standard level periodically.
6. Use control system for borrowing, loaning, and returning items and adjust inventory accordingly.
7. Follow up non-returned or missing articles.
8. Follow established surveillance policies.
9. Follow established placement policies.
10. Be observant, courteous and cooperative.

LEARNING ACTIVITIES

1. Visit a unit to learn where supply and inventory file is located.
2. Discuss the floor standard used by the local hospital in which student is receiving clinical experience.
3. Work with an experienced ward clerk in executing performance guides #3-9.
4. Listen to resource speaker (administrator) discuss the amount of money spent yearly for supplies and equipment and the reason that keeping accurate inventories is imperative.
5. Under the supervision of an experienced ward clerk, perform the task of maintaining the inventory and determining (when questioned) the amount of any specified article on hand. Based on the evaluation of the instructor, a rating of "fully accomplished" must be achieved.

RESOURCES

hospital administrator
experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms and file

EVALUATION

Using the inventory file of supplies and equipment provided, the student will maintain the inventory and determine the amount of any specified article on hand at any given time. A rating of "fully accomplished" by the instructor must be achieved. (The inventory must agree with the actual count of items for at least four out of five items.)

V-TECS 23
L.A. #5

STUDENT____________________________

DATE_______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Maintain inventories of supplies and equipment.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When maintaining inventories of supplies and equipment, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Obtained inventory file.	( )	( )	( )	( )	( )
2. Identified floor standard.	( )	( )	( )	( )	( )
3. Determined the amount of any specified article on hand at any given time.	( )	( )	( )	( )	( )
4. Followed established surveillance and placement policies.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Trace lost and found articles

PERFORMANCE OBJECTIVE

Given information concerning property control, one unclaimed wrist watch, and one claim of lost dentures, trace the location of the lost article and the identity of the owner of the found article. Found articles will be returned to owner and in case of lost articles, all due checks must have been made. (4)

PERFORMANCE GUIDE

1. Locate unit's system for control of lost and found articles.
2. Establish the identity of the person to whom a "found" article belongs by asking for a description of the found article.
3. Send unclaimed articles to designated place in hospital.
4. Establish validity of claim and organize a search for a lost article. Note: May involve many other hospital departments or units.
5. Notify security of loss claims if article cannot be located.
6. Initiate incident report after notifying security.

* S.C. writing team suggests an addition to listing:

7. If a patient leaves an article in room after being discharged, obtain patient's address and home telephone number. Notify by telephone.

LEARNING ACTIVITIES

1. Discuss the local hospital's system for handling lost-and-found articles.
2. Review several authentic records of items which have been reported lost and of articles which have been reported found. Compare to determine if a pattern seems to exist. (i.e., Are items in the bedside table drawer often left when patient is discharged?)
3. Investigate practical ways the ward clerk can minimize the number of articles lost.
4. Observe an experienced ward clerk handle a situation of a lost or found article.
5. In a mock situation in which two classmates play the role of owners, perform the task of tracing two lost and found articles. Role play the procedure, including telephone calls to security, etc. The performance must warrant a rating of "fully accomplished" by the instructor.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

articles (dentures and wrist watch)
incident report form

EVALUATION

Using hypothetical information and materials provided, the student will trace lost and found articles. A rating of "fully accomplished" must be achieved, based on the instructor's assessment that the found article has been returned to owner and all due checks have been made in the case of the lost article.

V-TECS 24
L.A. #5

STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Trace lost and found articles.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When tracing lost and found articles, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Established identity of person and secured description of lost or found article.	( )	( )	( )	( )	( )
2. Organized search for lost article.	( )	( )	( )	( )	( )
3. Notified security if article cannot be found.	( )	( )	( )	( )	( )
4. Completed incident report if necessary.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Obtain and charge special equipment

PERFORMANCE OBJECTIVE

Given a request for a cardiac monitor, charge forms, addressograph plate, and imprinter, obtain the monitor and prepare the charge form. The needed special equipment will be obtained within the time period specified, and the correct patient will be charged. (4)

PERFORMANCE GUIDE

1. Acknowledge the request. Special equipment may be obtained from many different areas of the hospital and is defined as:
   a. Cardiac monitoring devices, defibrillators, etc.
   b. Orthopedic frames, turning devices, walkers, crutches.
   c. Bed scales, hydraulic lifts.
   d. Oxygen administration equipment.
   e. Other items not ordinarily stocked on unit including unusual I.V. solutions.
2. Select correct requisition form and stamp it with the correct addressograph plate; complete the form.
3. Send the requisition to the concerned department at once or place the information in the computer.
4. Obtain and check the items ordered, sign for same, and annotate Kardex ...(or patient care form)... .
5. Place the items in designated area, or direct the technician where to place the equipment.
6. Report any problems or substitutions to the charge nurse.
7. Fill out and stamp a charge slip each day the equipment remains in use.
8. Route the charge slip, retaining the floor copy.

LEARNING ACTIVITIES

1. Discuss the kinds of special equipment dispersed throughout the local health care facility.
2. Display the forms used in the local health care facility for obtaining special equipment.
3. Using a transparency of an authentic requisition which has been filled out, discuss step-by-step the process of completing it.
4. Investigate and make a list of items that require charge slips (to be used later as reference). Refer to attached sample catalog.
5. Listen to experienced ward clerk explain a) which expenses are charged to the unit and which expenses are charged to the patient, b) substitutions which are commonly made, and c) daily record keeping responsibilities of the ward clerk as long as the equipment remains in use.

6. Perform the task of obtaining and preparing a charge form for a cardiac monitor. A rating of "fully accomplished" must be achieved, based on the evaluation of the instructor.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms
addressograph
overhead projector & transparencies

EVALUATION

Using the information and materials provided, the student will obtain and prepare a charge form for a cardiac monitor. The performance must warrant a rating of "fully accomplished" by the instructor.

V - TECS 25
L.A. #4

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07/26/82       ALPHABETIC CATALOG LISTING BY DEPARTMENT         PAGE
DEPT   ITEM   DESCRIPTION                          PRICE  UNIT   SUM    ACCT
146    8528   ADAPTIC DRESSING                      2.50          49    500-44
146    8529   ADAPTIC LARGE                         6.00          49    500-44
146    8500   CAST ARM LONG AD                     28.50   EA     49    500-44
146    8501   CAST ARM LONG CH                     20.00   EA     49    500-44
146    8502   CAST ARM SHORT AD                    21.00   EA     49    500-44

146    8503   CAST ARM SHORT CH                    17.50   EA     49    500-44
146    8508   CAST BODY AD                         41.00   EA     49    500-44
146    8509   CAST BODY CH                         29.50   EA     49    500-44
146    8510   CAST HAND AD                         17.00   EA     49    500-44
146    8511   CAST HAND CH                         16.00   EA     49    500-44
150    9211   Cast Shoe                            18.50
146    8514   CAST HEEL LG                          5.00   EA     49    500-44
146    8515   CAST HEEL MEDIUM                      5.00   EA     49    500-44
146    8516   CAST HEEL SMALL                       5.00   EA     49    500-44
146    8504   CAST LEG LONG AD                     44.00   EA     49    500-44
146    8505   CAST LEG LONG CH                     24.50   EA     49    500-44

146    8506   CAST LEG SHORT AD                    36.00   EA     49    500-44
146    8507   CAST LEG SHORT CH                    21.00   EA     49    500-44
146    8512   CAST REMOVAL AD                      16.50   EA     49    500-44
146    8513   CAST REMOVAL CH                      16.50   EA     49    500-44
146    8527   CAST ROOM                            11.50   EA     49    500-44

146    8530   FINGER SPLINTS                        5.00          49    500-44
146    8531   GLOVES STERILE                        2.50          49    500-44
146    8599   MISC ITEM                              .00   EA     49    500-44
146    8517   PLASTER 2 IN ROLL                     2.50   EA     49    500-44
146    8518   PLASTER 3 IN ROLL                     2.50   EA     49    500-44

146    8519   PLASTER 4 IN ROLL                     2.50   EA     49    500-44
146    8520   PLASTER 5 IN ROLL                     2.50   EA     49    500-44
146    8521   PLASTER 6 IN ROLL                     2.50   EA     49    500-44
146    8522   PLASTER 8 IN ROLL                     2.50   EA     49    500-44
146    8523   SOF ROLL 2IN X 4 YD                   2.50   EA     49    500-44

146    8532   STOCKINETT 2-12 IN                    2.50          49    500-44
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07/26/82       ALPHABETIC CATALOG LISTING BY DEPARTMENT
DEPT   ITEM   DESCRIPTION                          PRICE  UNIT   SUM    ACCT
150    9200   BALANCE TRACTION                     19.00   EA     04    500-50
150    9201   BRYANTS TRACTION                     12.50   EA     04    500-50
150    9202   BUCKS EXTENSION                      12.50   EA     04    500-50
150    9203   CERVICAL TRACTION                    12.50   EA     04    500-50
150    9210   FOOTBOARD                             5.00   EA     04    500-50

150    9209   HOYER LIFT                           37.50   EA     04    500-50
150    9211   MISC ITEM CODE                         .00   EA     04    500-50
150    9204   OVERHEAD FRAME                       25.00   EA     04    500-1.
150    9205   PELVIC SLING                          6.00   EA     04    500-50
150    9206   PELVIC TRACTION                      21.00   EA     04    500-50

150    9207   SIDE ARM TRACTION                    12.50   EA     04    500-50
150    9208   STRYKER FRAME                        37.50   EA     04    500-50
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BEST COPY AVAILABLE

STUDENT________________________________

DATE___________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Obtain and charge special equipment.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When obtaining and charging special equipment, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Obtained, prepared and processed charge form for special equipment.	( )	( )	( )	( )	( )
2. Obtained and checked the items ordered.	( )	( )	( )	( )	( )
3. Placed items in proper or designated area.	( )	( )	( )	( )	( )
4. Completed and routed a charge slip each day equipment remained in use.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Provide orientation to newly employed workers

PERFORMANCE OBJECTIVE

Given a newly employed worker, a written orientation plan, access to established policies, equipment and supplies, provide orientation for a newly employed worker. All items on the instructor's checklist must be rated "fully accomplished."

PERFORMANCE GUIDE

1. Obtain a written orientation plan outline and welcome the new person graciously. Note: Orientation programs should be planned in advance, and should include at least a written outline designed to ensure a thorough orientation for each new nursing employee. All new personnel should be made aware of the policies, goals, objectives and procedures of the nursing service and of the hospital, as well as of their job description, duties, and work area. **J.C.A.H.**, "Nursing Service Standard V."
2. Describe the ward clerk job to the new personnel.
3. Demonstrate poise, good grooming, self-confidence.
4. Identify tasks and limitations of each category of worker.
5. Introduce new worker to as many persons as practical.
6. Demonstrate and explain Kardex, charts, telephone system, and intercom, providing for note taking.
7. Explain desk routines concerning TPR's, diets, census sheets, condition sheet, supplies, charges, assignments, time sheets, accident and incident reports, infection control policies, lists.
8. Show location of desk supplies, equipment, procedure manuals.
9. Demonstrate complete clerical procedures associated with admission, transfer in -out -within, and discharge.
10. Demonstrate transcribing orders, lab, X-ray, medication, etc.
11. Explain inter- and intradepartmental relationships.
12. Explain special services/idiosyncracies concerning physicians.
13. Explain likes and dislikes of team leaders and head nurse.
14. Recognize and respond to feelings of insecurity in new person.
15. Recognize attention-span limits of new person.
16. Check off points covered on written orientation plan outline.
17. Arrange date and time to complete orientation plan.

LEARNING ACTIVITIES

1. Using a transparency, display a written orientation plan outline from the local health care facility. Discuss aloud.
2. As a homework assignment, write an outline of the areas which should be addressed during orientation, based on personal perspective.
3. Orally recite a description of the ward clerk job. Classmates will critique.

4. Visit a unit asking an experienced ward clerk to demonstrate performance of guides #6-13. Take notes.
5. Participate as an observer in the orientation of a newly employed worker. Later evaluate the strengths and weaknesses of the orientation.
6. In a mock situation, perform the task of providing orientation for a newly employed worker (role played by a classmate). Keep in mind the feelings of insecurity in the "new person" and the attention-span limits. All items on the instructor's checklist must be addressed; a rating of "fully accomplished" must be achieved, based on the evaluation of the instructor.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

orientation plan
overhead projector and transparency

EVALUATION

Using provided equipment, supplies, and information, the student will provide in a hypothetical situation an orientation for a newly employed worker. All items on the instructor's checklist must be addressed and performance must warrant a rating of "fully accomplished."

V-TECS 26
L.A. #6

STUDENT________________________

DATE__________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Provide orientation to newly employed workers.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When providing orientation to newly employed workers, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Displayed empathy toward new worker.	( )	( )	( )	( )	( )
2. Completed demonstration without error, having provided for note taking.	( )	( )	( )	( )	( )
3. Completed explanations understandably, logically, and factually (in "hospital" language).	( )	( )	( )	( )	( )
4. Provided breaks and time to absorb information.	( )	( )	( )	( )	( )
5. Checked off points covered on written orientation plan outline.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Prepare and route supply requisitions

PERFORMANCE OBJECTIVE

Given the required information, supplies and forms, prepare and route appropriate requisitions for stock supplies. Stock supply will be maintained within minimum and maximum levels for the given work area. Requisitions must be legible and routing procedure must follow established routine. (4)

PERFORMANCE GUIDE

1. Identify stock items using appropriate method (i.e., computer number, if applicable).
2. Identify standard level for each item.
3. Determine stock levels and compute the deficit.
4. Select appropriate requisition.
5. Prepare and route requisition to fill deficit, making certain that duplicates are legible.
6. Retain the floor copy in the appropriate file.
7. Enter information into computer if applicable.

LEARNING ACTIVITIES

1. Visit a unit to learn to identify stock supplies.
2. Visit the purchasing department (or appropriate "supply" department) to observe the process followed once a requisition is received.
3. Distribute sample requisition forms and discuss the procedure for filling them out.
4. Discuss the point that supplies are ordered on the basis of anticipated need; hence, wasting supplies will require additional requisitions and deliveries.
5. Observe an experienced ward clerk as he/she prepares and routes requisitions for stock supplies, demonstrating performance guides 2-7. Take notes for use later as a reference.
6. Under the supervision of an experienced ward clerk, perform the task of preparing and routing appropriate requisitions for stock supplies for one week. The performance must warrant a "fully accomplished" rating by the instructor.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms

EVALUATION

Using forms and information provided, the student will prepare and route requisitions for stock supplies for one week. Performance must warrant a rating of "fully accomplished" by the instructor.

V-TECS 27
L.A. #6

STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare and route supply requisitions.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing and routing supply requisitions, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Identified stock items against standard levels.	( )	( )	( )	( )	( )
2. Prepared and routed requisitions for stock supplies.	( )	( )	( )	( )	( )
3. Filed floor copy.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Assist in supervision of ward clerk students

PERFORMANCE OBJECTIVE

Given required information, supplies, equipment, and a ward clerk student to experience a new clinical situation, observe the student's activities and behavior for one day and report performance to the teaching institution and the supervisor. All items on the instructor's checklist must be rated "fully accomplished." (4)

PERFORMANCE GUIDE

1. Demonstrate willingness to accept student.
2. Assist in planning appropriate learning experience with instructor within expected developmental level of student ability and needs. Clinical experiences must be formally planned and include a method of evaluating the participant's performance.
3. Orient student to unit and demonstrate procedures as needed, using acceptable terminology.
4. Identify and accept performance standards of training institution.
5. Exhibit high quality performance of ward clerk skills.
6. Demonstrate acceptable grooming, promptness, and conduct.
7. Inspect work performed by student for accuracy and correct as needed. Annotate evaluation instrument.
8. Report significant facts regarding student's performance to the instructor.
9. Coordinate student activities with work load.
10. Notify student's instructor if work load will not permit time to be spent with student.
11. Provide sufficient time for student to practice new skills.
12. As opportunities for student to gain new skills arise, notify the instructor.

LEARNING ACTIVITIES

1. Review the pertinent points from Lesson 59, V-TECS OBJ. 26: "Provide orientation to newly employed workers."
2. Observe an experienced ward clerk assigned to supervise a ward clerk student who is experiencing a new clinical situation. Take extensive notes.
3. Report to classmates the strengths and weaknesses noted during learning activity #2, using performance guides 1-12 as basis for report.
4. Review the established performance standards of the health care facility training site. Discuss reason underlying each standard.
5. In a hypothetical situation, perform the task of assisting in the supervision of one student ward clerk (role played by a classmate) for one day. Use the local health care facility as the site for this performance so that supervision can be given from an

experienced ward clerk as well as the instructor. Performance on all items on the instructor's checklist must warrant a rating of "fully accomplished."

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

equipment & supplies customarily found in a unit

EVALUATION

Using information, materials, and student provided, the student will observe and report one student ward clerk's activities and behavior for one day. The circumstances will be hypothetical. Performance on all items of the instructor's checklist must warrant a rating of "fully accomplished."

V-TECS 28
L.A. #5

STUDENT____________________________

DATE_______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Assist in supervision of ward clerk students.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When assisting in the supervision of ward clerk students, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Demonstrated willingness to accept student.	( )	( )	( )	( )	( )
2. Served as an appropriate role model for student.	( )	( )	( )	( )	( )
3. Demonstrated acceptance of training institution standards.	( )	( )	( )	( )	( )
4. Recognized expected level of competence and needs of student.	( )	( )	( )	( )	( )
5. Oriented student to unit and demonstrated procedures as needed.	( )	( )	( )	( )	( )
6. Planned learning experiences with student's instructor, inspected work performed and made necessary corrections.	( )	( )	( )	( )	( )
7. Reported significant facts to student's instructor regarding student's performance.	( )	( )	( )	( )	( )
8. Notified student's instructor if work load would not permit time to be spent with student.	( )	( )	( )	( )	( )
9. Provided sufficient time for student to practice new skills.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Refer patient complaints or problems to a corrective department

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PERFORMANCE OBJECTIVE

Given three patient complaints of a varied nature and available resources, refer the complaints to the corrective department. Referral must be appropriate to the complaint as determined by the instructor considering the conditions present. (4)

PERFORMANCE GUIDE

1. Perceive and acknowledge complaint. Note: The ward clerk is often the first person on the nursing unit to receive signals indicating patient dissatisfactions. The patient has a right to expect considerate and respectful treatment at all times and under all circumstances. (**J.C.A.H.**, Patient's Rights.) Studies have shown that patients who bring suits usually have real or imagined grievances which considerate care and a "willingness to learn" may have prevented.
2. Respond positively in a reassuring manner.
3. Ask pertinent questions to elicit details tactfully.
4. Advise charge nurse if unable to handle problem.
5. Follow through to insure proper action.
6. Make certain that complaint is charted and signed by charge nurse if that is the policy of the institution.

LEARNING ACTIVITIES

1. Review pertinent points from Lesson 1, V-TECS OBJ. 6: "Greet and direct professionals, new patients, and visitors to patient location."
2. Research and write brief explanations of "libel" and "slander." Discuss in class. Note that treating patients with dignity and respect is necessary for their emotional well-being.
3. Discuss what constitutes good listening skills. Role play patient situations with classmates.
4. Read and discuss a "Patient's Bill of Rights," published by the American Hospital Association.
5. Inquire whether or not the local health care facility has a patient advocate or patient services representative, a person whose job is is to protect patient's rights in the health care facility. If so, invite this person as resource speaker.
6. Discuss the procedure to be followed in referring patient complaints to a corrective department.

7. Given three authentic patient complaints (provided by an experienced ward clerk), perform the task of receiving (via role play) and referring the patient complaints. (i.e., Verbally describe the measures which would be taken.) The ward clerk and the instructor will evaluate the performance. A rating of "fully accomplished" must ultimately be achieved.

RESOURCES

experienced ward clerk
Patient's Bill of Rights (American Hospital Association)

EVALUATION

Using provided resources/persons/information, the student will receive and refer three patient complaints. The performance must warrant a rating of "fully accomplished" by the instructor and experienced ward clerk.

V-TECS 29
L.A. #7

STUDENT______________________________

DATE__________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Refer patient complaints or problems to a corrective department.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When referring patient complaints or problems to a corrective department, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Received and acknowledged complaint(s).	( )	( )	( )	( )	( )
2. Referred complaint to corrective department and/or person.	( )	( )	( )	( )	( )
3. Charted complaint and referral.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Receive and store supplies and equipment

PERFORMANCE OBJECTIVE

Given a delivery of requested supplies and/or equipment, receive and store same. Nursing station will not be cluttered with newly delivered stock; items received will not be subject to theft, disfigurement, or rendered unusable, and will be found in their expected location. (4)

PERFORMANCE GUIDE

1. Locate floor copy of supply requisitions.
2. Verify items received with those requested. Note: May include nourishment supplies.
3. Sign the packing list form and file floor copy.
4. Place the new stock behind the old stock in designated place promptly.
5. Record supplies received on inventory file.
6. Do not allow supplies to be subjected to disfigurement, theft, or contamination.

LEARNING ACTIVITIES

1. Discuss the policy and procedure to be followed in verifying items received with those requested.
2. Visit unit to learn where floor copy of supply requisitions is kept.
3. Observe an experienced ward clerk demonstrating performance guides 3-5.
4. Discuss methods for preventing disfigurement, theft, or contamination of supplies.
5. Under the supervision of an experienced ward clerk, perform the task of receiving and properly storing supplies and equipment. Performance must warrant a rating of "fully accomplished" based on the evaluation of the instructor.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

supplies customarily found in unit
appropriate forms

EVALUATION

Using provided materials and forms, the student will receive and properly store supplies and equipment. Performance must warrant a rating of "fully accomplished" by the instructor.

V-TECS 30
L.A. #5

STUDENT____________________

DATE____________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Receive and store supplies and equipment.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When receiving and storing supplies and equipment, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Verified item received against requisition.	( )	( )	( )	( )	( )
2. Signed form and filed floor copy.	( )	( )	( )	( )	( )
3. Properly stored supplies and equipment.	( )	( )	( )	( )	( )
4. Recorded supplies received on inventory file.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Schedule patient treatments or therapy with other hospital departments

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PERFORMANCE OBJECTIVE

1. Interpret the order.
2. Identify the department concerned: Inhalation therapy, physical therapy, I.V. therapy, nuclear medicine, X-ray therapy, O.R. preparation, etc.
3. Call the appropriate department to set up appointment.
4. Transcribe information to Kardex ...(or care form)... and doctor's order sheet.
8. File the floor ...(or verification)... copy of the requisition.
9. Enter information into computer if applicable.
10. Imprint and add special therapy forms to patient's chart as needed.

LEARNING ACTIVITIES

1. Distribute the physician's orders which explain a directive to be taken (sample attached).
2. Study the local hospital organizational chart.
3. Discuss the function of each department.
4. Review each department's policy manual for later recall on a teacher-prepared test.
5. Demonstrate procedure for telephone calling, according to hospital policy.
6. Distribute the attached sample Diagnostic & Miscellaneous Procedures Form and discuss the procedure for completing.
7. Research and write a brief report explaining which procedures (e.g., X-ray, EKG, etc.) can be done together.
8. Discuss the procedure to be followed in filling out the requisition for the procedures. (Refer to attached information sheet titled "Special Notes on Procedures.")
9. Discuss procedure for providing escort and/or transportation services according to local hospital policy.
10. Distribute attached sample patient care form and review procedure for transcription.
11. Using other sample patient care forms, practice transcribing similar information as used in learning activity #10. (The instructor will provide the information and evaluate the results.)
12. Under the supervision of an experienced ward clerk, perform the task of scheduling one patient's radiation therapy with the hospital X-ray department. Evaluation by the instructor must result in a rating of "fully accomplished."

RESOURCES

experienced ward clerk
policy manuals of local hospital/health care facility

TOOLS AND EQUIPMENT

appropriate forms
physician's order

EVALUATION

Using provided information and material, the student will schedule one patient's radiation therapy with the hospital X-ray department. The performance must warrant a rating of "fully accomplished," by the instructor.

V - TECS 31
L.A. #1

PHYSICIAN'S ORDERS

AUTOMATIC STOP ORDER: SCHEDULE OF STOP DATES REPRODUCED BELOW IS IN TERMS OF DAYS FOLLOWING DATE OF ORIGINAL ORDER. IF STOP DATE FALLS ON SUNDAY OR HOLIDAY ORDER EXTENDED ONE DAY. TIME 11:00 A.M.

THIS ORDER DOES NOT APPLY WHEN PHYSICIAN'S ORDER INDICATES EXACT NUMBER OF DOSES AND/OR DAYS TO BE ADMINISTERED.

ANTIBIOTICS	7
SCHEDULE III MEDICATIONS	7
SCHEDULE II MEDICATIONS	3

DO NOT WRITE IN THIS SECTION IF RED ↑

(✓) START → HERE

DATE 1-10-83

TIME A.M. P.M.

ALLERGIES: Penicillin ←

(1)

(Use Red Ink)

Cat Scan of ABd in a.m.
Send Patients Chart to Department.

(ADDRESSOGRAPH)

M.D.
DISPENSE AS WRITTEN

M.D.
SUBSTITUTION PERMITTED

DO NOT WRITE IN THIS SECTION IF RED ↑

(✓) START → HERE

DATE

TIME A.M. P.M.

ALLERGIES: Penicillin

(2)

(ADDRESSOGRAPH)

M.D.
DISPENSE AS WRITTEN

M.D.
SUBSTITUTION PERMITTED

DO NOT WRITE IN THIS SECTION IF RED ↑

(✓) START → HERE

DATE

TIME A.M. P.M.

ALLERGIES: Penicillin

(3)

(Use Red Ink)

(ADDRESSOGRAPH)

M.D.
DISPENSE AS WRITTEN

M.D.
SUBSTITUTION PERMITTED

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Stamps

V - TECS 31
L.A. #6

(DIAGNOSTIC & MISCELLANEOUS PROCEDURES FORM)

(ADDRESSOGRAPH)

DATE	RN LPN	LAB, EKG, EEG	DATE	NURSE	DATE	RN LPN	X-RAY	DATE	NURSE

DATE	RN LPN	DAILY LAB, X-RAY, ETC	DATE	NURSE	DATE	RN LPN	PHYSICAL THERAPY	DATE	NURSE

DATE	RN LPN	NUCLEAR MEDICINE/ RADIATION THERAPY	DATE	NURSE	DATE	RN LPN	RESPIRATORY THERAPY	DATE	NURSE
'9	[illegible]	Cat Scan of ABD	6/10						

(Use Red Ink)

8/80

SPECIAL NOTES on PROCEDURES

Barium will interfere with the following:

1. Liver Scan
2. Abdominal Ultrasound
3. Pelvic Ultrasound
4. Gallium Acan

IVP examinations will effect Thyroid Uptake and Scan results; therefore, THYROID STUDIES NEED TO BE DONE BEFORE IVP EXAMS.

EXAMINATIONS ARE TO BE DONE IN THIS ORDER.

1. Scans/Ultra-sounds/Thyroid Studies

2. Cystograms and/or IVP's

3. Gallbladder

4. Lumbar Spine

5. Lower GI

6. Upper GI and/or small bowel and/or hypotonic duodenogram

NOTE: Chest, skull, bones, etc. can be done at anytime.

Skull x-rays preferrably should precede EEGS. If schedule does not permit, hair must be washed and dried before skull series can be done.

PROCEDURES DONE ON THE SAME DAY

There are many radiographic procedures which may be done on the same day and should be done on the same day to expedite a patient's stay in the hospital. All procedures that are to be done on the same day should be listed on the same requisition and one charge card attached.

Almost all procedures which DO NOT ENTAIL THE USE OF OPAQUE MEDIA can be done with any other examination. EXAMPLE: Chest and lumbar spine can be scheduled with an Upper GI.

**************** If there are any questions as to which procedures can be done together, please call Radiology at Ext. 5060 for information.

V - TECS 31
L.A. #10

PRE-OPERATIVE PATIENT

Admission Date ______ BATH: SELF ASSIST BED
Classification ______
Diet ______
Diet ______
Diagnosis ______
Surgery ______

ATTENDING PHYSICIANS
______ ______
______ ______

(Addressograph)

Date	Initials	PROBLEM	APPROACH	OUTCOME
			Vital signs (T, P, R, and BP) on admission and	Afebrile (less than
			@ HS prior to surgery and AM of surgery. Pre-	99.6) 12 hours prior
			pare for surgery as ordered:	to surgery. Estab-
			1.	lishment of baseline
			2.	vital signs.
			3.	
			4.	
			5.	
			6.	
			7.	
			8.	
			9.	
			10.	
			11.	
			12.	
				ACTIVITY
			Up ad lib unless contraindicated.	Ambulatory
				KNOWLEDGE
			1. Give verbal and/or written explanation of	Verbalizes instruc-
			preparation for surgery and of post-op care.	tions regarding pro-
✓		1A	Send chart c̄ Patient → Dept.	cedures and cooperat
				with plan of care.
	(Use Red Ink)		2. Explain operative permit to patient and	Informed consent.
			witness patient's signature.	

SCBH PATIENT CARE FORM

N-1 2/74

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V-TECS 31
L.A. #12

STUDENT______________________________

DATE________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Schedule patient treatments or therapy with other hospital departments.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When scheduling patient treatments on therapy with other hospital departments, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Verified physician's order.	( )	( )	( )	( )	( )
2. Scheduled patient's therapy or treatment with the appropriate department.	( )	( )	( )	( )	( )
3. Prepared proper requisition.	( )	( )	( )	( )	( )
4. Provided for special transportation if needed.	( )	( )	( )	( )	( )
5. Recorded arrangements made.	( )	( )	( )	( )	( )
6. Filed copy of requisition.	( )	( )	( )	( )	( )
7. Added forms to patient's chart as needed.	( )	( )	( )	( )	( )

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Select and mark needed special hour TPRs on worksheet

PERFORMANCE OBJECTIVE

Given the information concerning forty patients and the TPR worksheet, select and mark the 12:00 noon TPRs on the worksheet. The indications on the worksheet must agree with that of the instructor based upon the following: TPRs must be taken q.4.h. for all patients: (4)

1. who have had an elevation within the last 24 hours.
2. who are within the first 72-hour post op period.
3. who are within the first 72-hour post-partum period.
4. who have had special orders written.
5. who are receiving hypo- or hyperthermia treatments.

PERFORMANCE GUIDE

1. Obtain the TPR worksheet clipboard.
2. Check the surgery list.
3. Check the Kardex ...(or patient care form)... for special TPR orders.
4. Check for any elevations.
5. Indicate selection of patients on TPR worksheet.
6. If in doubt, consult charge nurse.
7. Replace clipboard.

LEARNING ACTIVITIES

1. Review pertinent points from Lesson 11, V-TECS OBJ. 40: Initiate graphic sheet.
2. Review pertinent points from Lesson 12, V-TECS OBJ. 77: Graph temperature, pulse, respiration.
3. Review pertinent points from Lesson 30, V-TECS OBJ. 70: Prepare and maintain TPR and diet worksheets.
4. Research and prepare a written report regarding the variety of reasons some patients have their vital signs taken more frequently than others.
5. Discuss the procedure of the local health care facility for selecting and monitoring type of patient discussed during learning activity #3.
6. Review the attached sample 24-hour record and graphic/intake-output record. Discuss the reasons for using different colors of ink and avoiding erasures.
7. Using blank forms and information provided by the instructor, practice completing the forms.
8. Discuss the reason for checking the surgery list and the Kardex or patient care form when completing the TPR worksheet.
9. Outline the process to be taken by the ward clerk after worksheet is completed and elevations are noted.

10. Under the supervision of an experienced ward clerk, perform the task of selecting patients who should have TPRs taken at noon and appropriately indicating on TPR worksheet. Based on the evaluation of the instructor, the performance must ultimately warrant a rating of "fully accomplished."

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms

EVALUATION

Using information and materials provided, the student will select patients who should have TPRs taken at 12:00 noon today and appropriately indicate on TPR worksheet. The performance must warrant a rating of "fully accomplished" based on the instructor's assessment.

V - TECS 32
L.A. #6

TWENTY-FOUR HOUR RECORD OF PATIENTS TEMPERATURES

(Weight and Elimination)

ROOM	NAME	WEIGHT	B/P	8 AM	12 NOON	4 PM	U	S	8 PM	12 MN	4 AM
#5	Nine Patient		110/60	99^{6}-96-20	100.84.20	97-60-18	1/1	0/0	98^{6}-82.20		
				98.64.20		100.76.20	0/0	1/1	100-78-18		
			150/94	100.84.18		99^{3}-80-18	1/11	0/0	99^{6}-96-20		
				96^{8}-98-20		97-82.20	0/0	1/1	97^{6}-82-20		
				101-86.20		101-104.20	1/11	0/0	96^{6}-50-20		
			120/80	97^{6}-82-18		97^{6}-84.20	0/0	1/1	98^{6}-68-18		
				96^{6}-70.20		99^{6}-66.18	0/0	0/0	99^{2}-60.18		
		152.		99-64.18		100^{1}-78-20	1/1	0/0	99^{4}-58-18		
				100.76.20		99-76-18	0/0	1/11	101-96-20		
				99^{8}-68-20		100^{1}-84-20	0/0	1/1	98^{2}-68-18		
				96^{5}-80-20		98^{8}-72-20	1/1	0/0	96^{6}-72-18		
				100-86-18		97^{5}-56-20	1/1	0/0	100-96-18		
			140/90	97^{6}-82-20		101^{2}-96-18	0/0	1/11	102-100-20		
				101-94-18		102-100-18	0/0	1/1	100-96-20		
				100.86-20		99^{6}-94-18			96^{6}-72-18		
				101-96-18		100-87-20			99^{2}-86-20		

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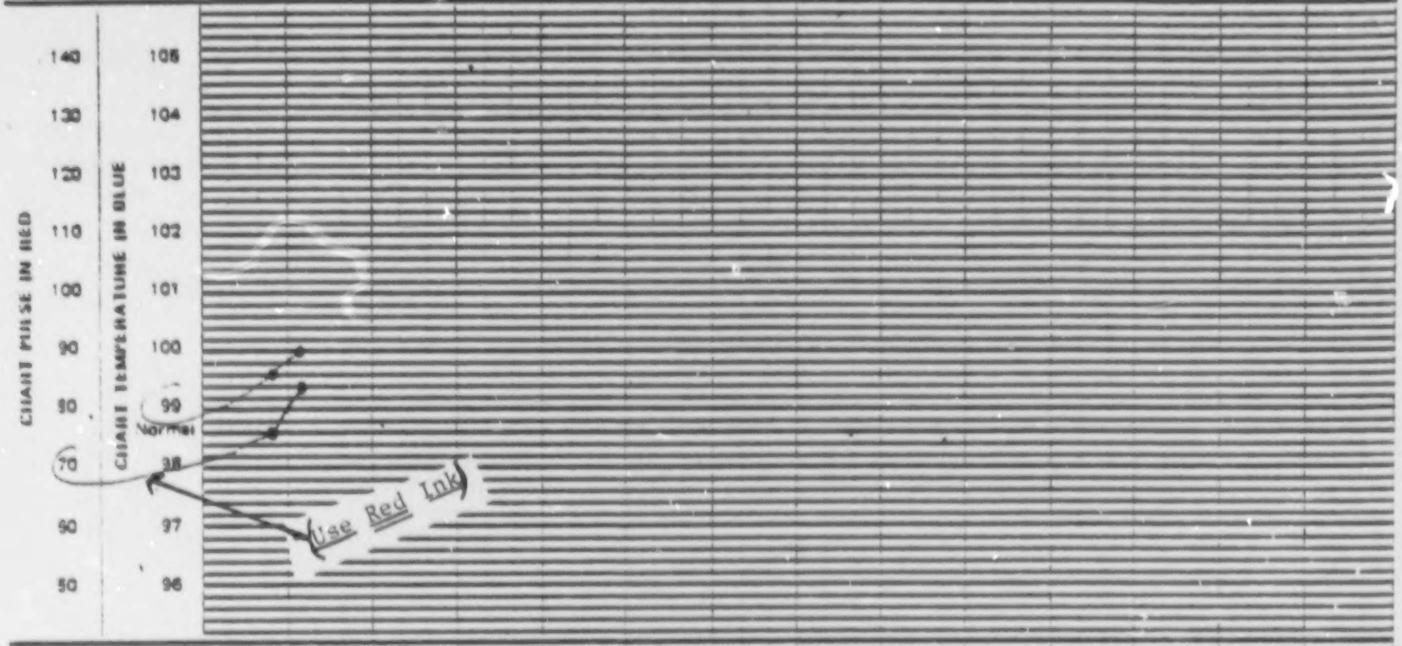
(Use Red Ink)

V - TECS 32
L.A. #6

GRAPHIC/INTAKE - OUTPUT RECORD

(ADDRESSOGRAPH)

DATE	1. 2. 83		1. 3		1- 4		1- 5		1- 6		1- 7		1- 8	
HOSP. DAY/PO-PP	Adm		1	PO	2	1	3	2	4	3	5	4	6	5
HOUR	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8



RESPIRATIONS	24	22												
BP S	110													
BP D	60													
Weight Urine Stools	132.													
B'Fast Lunch Dinner	1/2 all 3/4													
Other Dietary Intake														

DATE	INTAKE				OUTPUT			
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

DATE	INTAKE				OUTPUT			
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

DATE	INTAKE				OUTPUT			
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

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V - TECS 32
L.A. #7

GRAPHIC/INTAKE – OUTPUT RECORD

(ADDRESSOGRAPH)

DATE														
HOSP. DAY/PO-PP														
HOUR	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8	12 4 8

CHART PULSE IN RED	CHART TEMPERATURE IN BLUE														
140	105														
130	104														
120	103														
110	102														
100	101														
90	100														
80	99														
	Normal														
70	98														
60	97														
50	96														

RESPIRATIONS														
BP S														
BP D														
Weight/Urine/Stools														
B'Fast/Lunch/Dinner														
Other Dietary Intake														

DATE		INTAKE				OUTPUT		
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

DATE		INTAKE				OUTPUT		
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

DATE		INTAKE				OUTPUT		
TIME	MOUTH	PARENTERAL		TOTAL	URINE			TOTAL
10 - 6								
6 - 2								
2 - 10								
24 HR. TOTAL								

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V-TECS 32
L.A. #10

STUDENT ____________________

DATE ____________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Select and mark needed special hour TPR's on work sheet (graphic sheet).

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When selecting and marking needed special hour TPRs on worksheet, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Selected and marked the 12:00 noon TPRs on the worksheet using patient information provided by the instructor.	( )	( )	( )	( )	( )
2. Identified elevated temperatures.	( )	( )	( )	( )	( )
3. Checked worksheet and surgery patients.	( )	( )	( )	( )	( )

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*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING MANAGERIAL ACTIVITIES

TASK: Trace missing lab specimen or reports

PERFORMANCE OBJECTIVE

Given a situation where a diagnostic report is unavailable at a specified time, trace through necessary logs and/or departments until found or further directives are issued. Patient therapy will not be jeopardized through missing diagnostic reports upon which medical judgments are made. (4)

PERFORMANCE GUIDE

1. Locate floor copy of lab requisition and determine whether or not specimen was clocked in.
2. Check master diagnostic therapy book to determine if lab technician has signed book.
3. Check nurses' notes for time specimen was collected.
4. Look at lab reports on all charts to determine if the report was misfiled.
5. Call lab to locate report, if available, and obtain a new chart copy.
6. Consult charge nurse for further directives if lab has no record of request.
7. Determine whether an incident report must be filed.
8. Recall above information from computer memory bank if applicable.

LEARNING ACTIVITIES

1. Visit a unit to observe an experienced ward clerk demonstrate performance guides 1-8. Take notes for future reference.
2. Listen to resource speaker (physician) discuss the reasons for rating as "high" the criticality of the task of requesting laboratory services. For example, physicians rely on laboratory test results; delays and errors are costly; delays may be hazardous to the patient's comfort and welfare.
3. Review as homework assignment the pertinent points from Lesson 16, V-TECS OBJ. 51: Prepare requisitions for routine diagnostic tests.
4. Review in small group pertinent points from Lesson 40, V-TECS OBJ. 61: Prepare lab requisition forms.
5. Read policy manual of local health care facility regarding procedure to be followed in tracing a lab specimen or report. Extract the responsibilities of the ward clerk.
6. Under the supervision of an experienced ward clerk, perform the task of tracing a (real or hypothetical) missing diagnostic report. Performance must warrant a rating of "fully accomplished," based on the evaluation of the instructor.

RESOURCES

physician
experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms, reports, master diagnostic therapy book

EVALUATION

Using provided materials and information, the student will trace a missing diagnostic report. Performance must warrant a rating of "fully accomplished," based on the assessment of the instructor.

V-TECS 33
L.A. #6

STUDENT______________________________

DATE________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Trace missing lab specimen or reports.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When tracing missing lab specimen or reports, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Determined whether or not a lab report was missing.	( )	( )	( )	( )	( )
2. Called lab; obtained new chart copy, if available.	( )	( )	( )	( )	( )
3. Consulted charge nurse for further directive.	( )	( )	( )	( )	( )
4. Filed an incident report if necessary.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECORD KEEPING ACTIVITIES

TASK: Prepare and maintain daily census sheet

PERFORMANCE OBJECTIVE

Given yesterday's "Daily Floor Census" form with information reflecting ward clerk activity from 11:00 p.m. to 7:00 a.m., and access to required forms, prepare a daily floor census form (in duplicate). No data will be omitted and all entries must be without error. (4)

PERFORMANCE GUIDE*

1. Obtain the daily floor census form(s) (sample attached).
2. Fill in headings: floor, section, today's date.
3. Fill in all columns of Line 1, "Remaining Last Report" from Line 9 of yesterday's report.
4. Enter in space provided the hospital number, room number, name, service and time of each admission, discharge, transfer-in, transfer-out, death.
5. At midnight, fill in Lines 2, 3, 4, 5, 6, 7, 8, and 9.
6. Send one copy to medical records room or business office.
7. File the retained copy (by date) for reference and statistical purposes.

* South Carolina writing team suggests a revised listing of the performance guide. Refer to the following revised performance guide.

SOUTH CAROLINA PERFORMANCE GUIDE

1. Place two census forms with carbon between them into census book (sample form attached).
2. Fill in headings: unit and today's date.
3. Fill in all columns of line 1, "Remaining Last Report" from line 7 of previous day's report in male/female divisions.
4. Enter in space provided the room number, bed number, name and time of each admission, discharge, transfer-in, transfer-out, death.
5. At 10:30 p.m., fill in lines 2, 3, 4, 5, 6 and 7 and take or send original copy to admitting office. All transfer-in patients will have a patient activity slip (sample attached) completed by transferring unit. Place activity slips in census book and take to admitting with census form.
6. Leave carbon copy in book on unit for 5 days; then discard.

LEARNING ACTIVITIES

1. Visit a unit to learn where census forms, carbon, and census book are kept.
2. Interview unit personnel to discover the reason for preparing and maintaining a daily census sheet (i.e., What use is made of it by the admitting office? Elsewhere?).

BEST COPY AVAILABLE

3. Research and report the definition and use of the master census.
4. Distribute sample blank forms, practice entering information (supplied by the instructor) in the appropriate places. Evaluate each other's work.
5. Under the supervision of an experienced ward clerk, perform the task of preparing a daily census form (in duplicate). No errors are allowed. The performance will be evaluated by the ward clerk and instructor. A rating of "fully accomplished" is expected.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

census forms and book

EVALUATION

Using information provided, the student will prepare and maintain a daily floor census form. No errors are allowed. Performance of the task must warrant a rating of "fully accomplished," based on the assessment of the instructor and participating ward clerk.

CENSUS REPORT

Fill in Census Report as you admit, discharge, transfer, or for a death.

Make two copies, by placing a carbon in. Complete by 10:30PM. PM Ward Clerk will take top (original) copy to Admitting by 10:30PM daily. Leave carbon in census book, placing a clean sheet on top of carbon with tomorrow's date in book.

Patient Activity Requisition: take to Admitting with the Census Report.

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DAILY FLOOR CENSUS

For 24 Hours Ended Midnight

FLOOR__________ SECTION__________ __________ DATE__________ 19____

		MALE							FEMALE									
Line No.		MED.	SURG.		OTHER	PED	NEW-BORN		MED.	SURG.	O.B.	GYN.		OTHER	PED	NEW-BORN		TOTAL
1	Beginning Last Report																	
2	Admitted																	
3	Received By Transfer																	
4	TOTAL Sum of lines 1, 2, & 3																	
5	Discharged																	
6	Discharged By Transfer																	
7	Dead																	
8	TOTAL Sum of lines 5, 6, & 7																	
9	Beginning 12:00 Midnight																	

ADMITTED (Line 2)

Hosp. No.	Room No.	NAME	TIME

DISCHARGED (Line 5)

Hosp. No.	Room No.	NAME	TOTAL

RECEIVED BY TRANSFER (Line 3)

DISCHARGED BY TRANSFER (Line 6)

STILLBIRTHS

DIED (Line 7)

NOTE: Use information cited on census form attached for use with S.C. Performance Guide #1.

or

Use information supplied by the instructor.

V - TECS 82
S. C: Performance Guide #1

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DAILY CENSUS REPORT

FLOOR 3rd - Long CENSUS 12:00 MIDNIGHT 12- 15 DA

ADMISSIONS

NO	TIME	NAME
392-1	2 45 PM	Miss Ann Maginnis
301-1	3:10 PM	Mrs Ruth Boozer
305-2	3:00 PM	Mrs Mary Rhinehart
305-1	3:40 PM	Mrs Elizabeth Bradham
3 72-2	4:05 PM	Mrs Cecil Dial
309-1	4 10 PM	Mrs Betty Koon

DISCHARGES

	NO.	TIME	NAME
301	1	9:50 AM	Mr. Willie Calder

RECEIVED BY TRANSFER

NO.	FROM DIV.	NAME
394-1	I.C.U. #3	Fred Flagg
374-2	206	Horace Holmes
302	I.C.2 #2	Sam Surrey

DISCHARGED BY TRANSFER

NO.	TO DIV.	NAME

309-1 to 309-2 Koon

DEATHS

NO.	TIME	NAME

	MALE Adult	MALE Newborn	FEMALE Adult	FEMALE Newborn
Remaining Last Report	4		5	
Admitted	0		5	
Received Per Transfer	3		0	
Total	7		10	
Discharged	1		0	
Died	0		0	
Remaining 12:00 Midnight	6		10	

448 Total - 16

Form A1-2 4/74

DAILY CENSUS REPORT

FLOOR ____________________ CENSUS 12:00 MIDNIGHT ____________________ DAT

ADMISSIONS

NO.	TIME	NAME

DISCHARGES

NO.	TIME	NAME

RECEIVED BY TRANSFER

NO.	FROM DIV.	NAME

DISCHARGED BY TRANSFER

NO.	TO DIV.	NAME

DEATHS

NO.	TIME	NAME

	MALE		FEMALE	
	Adult	Newborn	Adult	Newborn
Remaining Last Report				
Admitted				
Received Per Transfer				
Total				
Discharged				
Died				
Remaining 12:00 Midnight				

Form AI-2 4/74

BEST COPY AVAILABLE

BEST COPY AVAILABLE

PATIENT ACTIVITY

PATIENT ACTIVITY

COMPLETED BY ______________________

☐ DECEASED

MONEY RECEIVED ON DISCHARGE $ ______________

DISCHARGE	TAKE HOME DRUGS ☐	NO CHARGES ATTACHED ☐	ROOM / BED		TIME: HOUR / MIN
TRANSFER	PATIENT NUMBER		ROOM / BED	TO	ROOM / BED

V-TECS 82
L.A. #5

STUDENT__________________________

DATE____________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare and maintain daily census sheet.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing and maintaining daily census sheet, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Obtained and prepared daily floor census.	( )	( )	( )	( )	( )
2. Routed copies to appropriate locations.	( )	( )	( )	( )	( )
3. Filed floor copy in proper location.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECORD KEEPING ACTIVITIES

TASK: Add chart forms as needed

PERFORMANCE OBJECTIVE

Given required supplies and the charts of forty patients, determine that each chart has sufficient space available on all chart forms for the next 24 hours. No doctor or nurse will need to locate, imprint and add forms before performing their charting activities except in a most unusual emergency situation. All forms added must be addressographed with correct plate and placed in designated location in chart. (4)

PERFORMANCE GUIDE

1. Determine space available on nurses' notes sheets once each shift.
2. Determine space available on doctor's order sheets before and after each physician's visit. Note: Many hospitals are now using a doctor's order sheet with chemically treated carbon sets on which the physician may write no more than three sets of orders.
3. Determine space available on progress notes sheet before and after each physician's visit.
4. Determine space available on graphic sheet once daily.
5. Determine space available on special chart forms such as diabetic record or prothrombin record once each shift.
6. Ascertain probable discharge date of patient and add new addressographed sheets to provide space for next 24 hours.
7. Conserve supplies as much as possible.

LEARNING ACTIVITIES

1. Prepare for debate in class the topic: Management by Planning vs. Management by Crisis.
2. In small groups discuss ways the ward clerk can use spare time to an advantage. Share conclusions with entire class.
3. Visit a unit to observe an experienced ward clerk demonstrate performance guides #1-6. Assist if asked.
4. Review the types of forms (and their order of placement) in the chart. Practice appropriately addressographing them and completing any date lines.
5. Under the supervision of an experienced ward clerk, perform the task of imprinting and adding needed chart forms for forty charts (for one 24-hour period). The performance must warrant a rating of "fully accomplished," based on the evaluation of the instructor.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms
addressograph

BEST COPY AVAILABLE

EVALUATION

Using supplies provided, the student will imprint and add needed chart forms for forty charts for the next 24-hour needs. The performance must warrant a rating of "fully accomplished" by the instructor.

V-TECS 78
L.A. #5

STUDENT ____________________

DATE ____________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Add chart forms as needed.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When adding chart forms, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Determined available space on selected chart forms.	( )	( )	( )	( )	( )
2. Added chart forms as needed.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECORD KEEPING ACTIVITIES

TASK: Obtain and safeguard prior admission chart

PERFORMANCE OBJECTIVE

Given a request for the prior admission chart(s) of three patients, with access to required information and standard policies, obtain and safeguard the old charts when received. No patient's prior admission chart(s) will be lost, altered in any manner, or be given to unauthorized persons. Charts received must be those requested. (4)

PERFORMANCE GUIDE

1. Determine that person requesting old chart is authorized by this hospital's policy to have it.
2. Prepare complete identification of patient, name, room number, hospital number, birth date, place of birth, sex, and race from the admission summary sheet.
3. Call medical records room giving the above information, or send memorandum.
4. Old charts will be delivered to you; or you may be called to come for them when they are located and sign for them.
5. Put old chart(s) with current chart and maintain surveillance.
6. Send old chart(s) to medical records with the current chart to establish the integrity of the complete record when patient is discharged.

LEARNING ACTIVITIES

1. Discuss who among hospital personnel are given authorization to obtain old charts based on the policy of the local hospital.
2. Observe a resource person (English teacher) as he/she demonstrates the art of writing a concise, complete, and coherent memorandum.
3. Practice writing a sample request to obtain a prior admission chart.
4. Discuss the importance of checking for and sending old charts to record room when patient is discharged.
5. Listen to an experienced ward clerk discuss the best approach to performing performance guides #1-6. Take notes.
6. With the assistance of an experienced ward clerk, perform the task of obtaining prior admission charts of three patients. A rating of "fully accomplished" must be achieved, based on the evaluation of the instructor.

RESOURCES

English teacher
experienced ward clerk

TOOLS AND EQUIPMENT

appropriate charts
paper suitable for writing a memorandum

EVALUATION

Using provided information and materials, the student will obtain the prior admission charts of three patients. Safeguarding measures must be exerted. The performance must earn a rating of "fully accomplished," based on the assessment of the instructor.

V-TECS 79
L.A. #6

STUDENT______________________________

DATE_________________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Obtain and safeguard prior admission chart.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When obtaining and safeguarding prior admission chart, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Obtained the prior admission charts of selected patients.	( )	( )	( )	( )	( )
2. Placed old charts with current charts and maintained surveillance.	( )	( )	( )	( )	( )
3. Processed completed chart to medical records when patient discharged.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

V-TECS 80

DUTY: PERFORMING RECORD KEEPING ACTIVITIES

TASK: Post all diagnostic reports on charts

PERFORMANCE OBJECTIVE

Given the charts of forty patients and the diagnostic reports for one eight-hour shift, post the reports. No report will be misfiled. Reports must be on the corresponding patient's chart, in consecutive order and in designated location. (4)

PERFORMANCE GUIDE

1. Determine that charge nurse has initialed report or ...
2. Report abnormal findings of diagnostic tests to charge nurse. Note: Task is sometimes performed by laboratory personnel, in which event it may be the responsibility of the ward clerk to determine accuracy of posting and/or to report abnormal findings to charge nurse.
3. Separate reports into groups, i.e., lab reports, X-ray reports, and other reports or ...
4. Separate reports by patient's name.
5. Locate patient's chart, match identifying data with report. Name and hospital number are identifying data, room or bed numbers are not!
6. Post lab reports on lab report sheet consecutively; initial if applicable.
7. Post X-ray reports in designated location in chart; initial if applicable.
9. Return chart to rack or carousel.
10. Special diagnostic reports such as tissue specimen reports are generally placed in front of chart until seen by physician, then posted in designated location in chart.
11. Ward clerks are often asked by physicians and nurses to call laboratories to obtain reports of various tests; ...(or often a laboratory staff member calls the ward clerk and gives diagnostic test results)... . If asked to call, call the laboratory, giving your name and location and request the report needed, verifying the patient's name, room number, and physician; write the report legibly on a memo with the patient's name and room number; read back what you have written to the lab to verify the information. CAUTION: Medical and nursing judgment are based on these reports. Give the memo to the physician or nurse; the lab will send the official report to be posted in the routine manner.

LEARNING ACTIVITIES

1. Review pertinent points from Lesson 16, V-TECS OBJ. 51: Prepare requisitions for routine diagnostic tests.
2. Review the various groups of reports and their overall purpose.

3. Observe an experienced ward clerk demonstrate the best approach to performing performance guides 1-11. Take extensive notes for later reference.
4. Practice sorting charts into groups and separating them according to identifying data.
5. Review the sequence to be followed in organizing reports in charts.
6. Under the close supervision of an experienced ward clerk, perform the task of posting all diagnostic reports on the charts of forty patients (for one eight-hour shift). A rating of "fully accomplished" must be achieved, based on the evaluation of the instructor.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms
patient's charts

EVALUATION

Given the necessary materials, the student will accurately post all diagnostic reports on the charts of forty patients for one eight-hour shift. The performance must warrant a rating of "fully accomplished," based on the assessment of the instructor.

V-TECS 80
L.A. #6

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Post all diagnostic reports on charts.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

	Student Performance				
When posting all diagnostic reports on charts, the student:	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Determined that charge nurse had initialed report.	( )	( )	( )	( )	( )
2. Posted diagnostic reports on proper sheets.	( )	( )	( )	( )	( )
3. Called laboratories to obtain reports of various tests using the proper hospital policies.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECORD KEEPING ACTIVITIES

TASK: Prepare and add supplemental forms to charts such as diabetic record, coagulation record, physical therapy record, etc.

PERFORMANCE OBJECTIVE

Given access to required supplies and information concerning the need for supplemental forms to be added to six charts, identify, prepare, and add the supplemental forms. Supplemental form selected must be that designed for this purpose, present when needed, and appropriately stamped. (4)

PERFORMANCE GUIDE

1. Associate supplemental form needs with diagnosis. Supplemental forms are defined as those forms pertaining to a doctor's order, specific illness, or specialty area. Generally they include diabetic record sheets, coagulation record sheets, intake and output summary sheets, consultation sheets, transfusion record sheets, intravenous records, physical therapy record sheets, inhalation therapy record sheets, flow charts, BP graph sheets, incident records, special release forms, and others.
2. Associate supplemental form needs with doctor's orders.
3. Identify supplemental form needed or requested.
4. Imprint with patient's addressograph plate.
5. Fill in special information such as date and time if applicable.
6. Place in designated location on chart.
7. Monitor space available and add as needed.
8. Incorporate supplemental forms in discharge chart.
9. Conserve supplies.

LEARNING ACTIVITIES

1. Review the various chart forms which are used in the local health care facility.
2. Discuss the identification of forms which must be "supplemental" and the reason that they are defined as such.
3. Using a transparency, demonstrate the procedure for preparing a supplemental form (sample attached).
4. Discuss the procedure for adding supplemental forms to chart.
5. Observe a demonstration, by an experienced ward clerk, in the correct way to identify, prepare, and add supplemental forms. Take notes for later reference.
6. Practice identifying and preparing supplemental forms for inclusions in at least 3 authentic charts. Discuss with instructor the accuracy of the task performance.
7. Under the supervision of an experienced ward clerk, perform the task of identifying, preparing, and placing the supplemental forms needed in the charts of six patients. A rating of "fully accomplished" must be earned, based on the evaluation of the instructor.

RESOURCES
experienced ward clerk

TOOLS AND EQUIPMENT
addressograph
appropriate forms
overhead projector & transparencies

EVALUATION
Using provided materials and information, the student will accurately identify, prepare, and place the supplemental forms needed in the charts of six patients. A rating of "fully accomplished" must be achieved, based on the assessment of the instructor.

V - TECS 81
L.A. #3

DIABETIC CHART

Addressograph

AGE HT. WT. DIET

	INSULIN				URINE								MISCELLANEOUS	BLOOD SUGAR
Date	A.M.	Noon	P.M.		7:30		11:30		4:30		9:00			
					s	a	s	a	s	a	s	a		

ABBREVIATIONS AND SYMBOLS

INSULIN		SUGAR	ACETONE
Regular	R	0	0
Protamine Zinc	P.Z.	1+	1+
Globin	G	2+	2+
NPH	N	3+	3+
Lente	L	4+	
		Top Block	Bottom Block

V-TECS 81
L.A. #7

STUDENT__________________________

DATE____________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:
Prepare and add supplemental forms to charts such as diabetic record, coagulation record, physical therapy record, etc.
Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing and adding supplemental forms to charts; the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Identified (6) patient charts that need supplemental forms.	( )	( )	( )	( )	( )
2. Identified and prepared the appropriate supplemental forms.	( )	( )	( )	( )	( )
3. Added supplemental forms to the (6) charts.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: PERFORMING RECORD KEEPING ACTIVITIES

TASK: Prepare, maintain, and post/route lists

PERFORMANCE OBJECTIVE

Provided access to sources of data and forms, prepare and post one each of the following lists: (a) Nourishment b) Lab/X-ray (c) Staff Assignments (d) Condition. Each list must be 100 percent accurate, and the posting/routing procedure must meet the instructor's approval. (4)

PERFORMANCE GUIDE

1. Locate the source(s) from which the data is to be extracted.
2. Determine the correct form.
3. Verify the information, checking with the charge nurse if in doubt.
4. Compile the list.
5. Use the correct color of ink and write legibly.
6. Make certain that any duplicates are legible.
7. Secure initialing by the charge nurse.
8. Post/route the prepared list. Lists included are those which provide answers to most frequently asked questions; minimize traffic in the nursing station; expedite patient care; conserve linen and supplies; provide directions for maids, porters, orderlies, volunteers and others; provide records from which nursing audits are performed; provide records of stated preferences of days off, holiday and vacation requests.
9. Alter posted lists as indicated by changes occurring.
10. Recopy lists when needed.
11. Make certain that bulletin boards contain only pertinent, factual, current information, and that appearance of bulletin board is neat.

LEARNING ACTIVITIES

1. Discuss examples of lists associated with (a) Nourishment, (b) Lab/X-ray, (c) Staff Assignments, (d) Condition.
2. Discuss methods for securing verification of information.
3. Outline on board the major points to be addressed in preparing a list (e.g., using correct color of ink; securing initials of charge nurse, etc.).
4. Listen to resource speaker (charge nurse) describe a well-managed, efficient unit (i.e., how the lists are maintained and posted/routed).
5. Visit a unit and observe a good example of a well-kept bulletin board. (Rely on judgment of instructor.) Write the reasons which cause the bulletin board to be useful.
6. Visit a unit to observe an experienced ward clerk demonstrating performance guides 1-14. Take notes for reference later.
7. Under the supervision of an experienced ward clerk, perform for an evaluation by the instructor the task of preparing, maintaining, and posting/routing four lists. No errors are allowed.

RESOURCES

charge nurse
experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms

EVALUATION

Using provided material and information, the student will prepare, maintain, and post/route four lists as directed. One hundred percent accuracy must be maintained. A rating of "fully accomplished" must be achieved, based on the assessment of the instructor.

V-TECS 8
L.A. #7

STUDENT______________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare, maintain, and post/route lists.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of FULLY ACCOMPLISHED (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing, maintaining, and posting/routing lists, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Obtained correct form and prepared one each of the following lists:					
a. Nourishment	( )	( )	( )	( )	( )
b. Lab/X-ray	( )	( )	( )	( )	( )
c. Staff Assignments	( )	( )	( )	( )	( )
d. Condition	( )	( )	( )	( )	( )
2. Posted/routed the prepared list.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: MAINTAINING ENVIRONMENTAL SAFETY AND SANITATION

TASK: Prepare for ordered isolation care

PERFORMANCE OBJECTIVE

Given established policies, an order for a patient to be isolated, and access to all needed forms, information, equipment, prepare for ordered care, either protective or precautionary. All preparations must conform to specifications published by the infection control committee. (4)

PERFORMANCE GUIDE

1. Identify type of isolation, confer with charge nurse. Note: Hospital policy will dictate whether or not patient must be moved to another location. If so, physician must be informed and give his/her consent for the transfer.
2. Transcribe the order to the patient's Kardex ...{or patient care form in notebook}... .
3. Notify the nursing personnel assigned to this patient's unit ...{and flag chart with sticker}... .
4. Select the correct door sign and patient information leaflet for type of isolation ordered.
5. Give patient the information leaflet or have patient told about the order.
6. Place the sign in designated location.
7. Notify housekeeping department and order the isolation supplies.
8. Notify business office, information desk, and dietary department.
9. Monitor the quantity of supplies on hand each shift.
10. When isolaion is discontinued, notify housekeeping department.
11. Enter information into computer if applicable.

LEARNING ACTIVITIES

1. Research for class report the reasons for medical isolation.
2. Discuss the types of isolation precautions generally used (e.g., respiratory precautions, enteric precautions, skin and wound precautions, strict isolation, reverse isolation).
3. Outline and study for later recall on a teacher-prepared test the responsibilities of the ward clerk regarding ordered isolation care (e.g., ordering items such as gowns, caps, etc.).
4. Read aloud the isolation care specifications published by the infection control committee of the local health care facility.
5. Visit a unit to observe an experienced ward clerk demonstrate performance guides #1-11. Take notes.
6. Under the supervision of an experienced ward clerk, perform the task of preparing for ordered isolation care. A rating of "fully accomplished" must be achieved, based on the assessment of the instructor.

RESOURCES

experienced ward clerk

TOOLS AND EQUIPMENT

appropriate forms, signs/stickers

EVALUATION

Using provided materials, the student will prepare for ordered isolation care, conforming to specifications published by the infection control committee. A rating of "fully accomplished" must be achieved, based on the assessment of the instructor.

V-TECS 83
L.A. #6

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Prepare for ordered isolation care.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When preparing for ordered isolation care, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Verified type of isolation ordered.	( )	( )	( )	( )	( )
2. Processed the order.	( )	( )	( )	( )	( )
3. Notified appropriate departments when isolation care is established and/or discontinued.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: MAINTAINING ENVIRONMENTAL SAFETY AND SANITATION

TASK: Plan/execute nursing station sanitizing

PERFORMANCE OBJECTIVE

Given required supplies, plan/execute nursing station sanitizing. The nursing station must meet specifications of cleanliness and appearance at any unspecified inspection period. (4)

PERFORMANCE GUIDE

1. Damp-dust desks, shelves, chart racks, and other equipment daily with properly diluted disinfectant solution. Note: Environment factors in the nursing station will influence the speed and effectiveness of all personnel caring for the patients on that unit, as well as affect the possibility of cross-infection. Because of the sensitive nature of the materials in the nursing station, housekeeping personnel are often reluctant to, or sometimes restricted from, entering the nursing station.
2. Clean the addressograph machine and intercom.
3. Sanitize the telephone equipment.
4. Sanitize chart backs after discharges occur.

LEARNING ACTIVITIES

1. Listen to resource speaker (infection control nurse) address the topic of cross-infection.
2. Investigate ways a ward clerk can maintain an orderly working area at the nurses' station, thereby keeping confusion to a minimum.
3. Discuss the reason(s) many ward clerks prefer to execute sanitizing chores at the nurses' station without the aid of the housekeeping staff (e.g., to protect confidentiality by reducing the number of people working in the nurses' station).
4. Visit a unit within the local health care facility to discover where sanitizing supplies are kept.
5. Observe the methods used by an experienced ward clerk as he/she demonstrates performance guides #1-4.
6. Perform the task of planning (i.e., writing a checklist) and executing the sanitizing of a nurses' station (real or simulated). A rating of "fully accomplished" must be achieved, based on the evaluation of the instructor.

RESOURCES

infection control nurse
experienced ward clerk

TOOLS AND EQUIPMENT

sanitizing supplies

BEST COPY AVAILABLE

EVALUATION

Using an assigned nursing unit and supplies available, the student will plan/execute nursing station sanitizing. A rating of "fully accomplished" must be achieved, based on the assessment of the instructor.

V-TECS 84
L.A. #6

STUDENT________________________

DATE__________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Plan/execute nursing station sanitizing.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When planning/executing nursing station sanitizing, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Prepared a checklist.	( )	( )	( )	( )	( )
2. Executed nursing station sanitizing.					
a. Cleaned the addressograph machine and intercom.	( )	( )	( )	( )	( )
b. Sanitized the telephone equipment.	( )	( )	( )	( )	( )
c. Sanitized chart backs after discharge of patient.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

BEST COPY AVAILABLE

DUTY: MAINTAINING ENVIRONMENTAL SAFETY AND SANITATION

TASK: Enforce regulations governing care of charts

PERFORMANCE OBJECTIVE

Given the charts of forty patients and a standard policy manual: enforce regulations governing care of charts as written in the policy manual. No chart will be unaccounted for during this tour of duty, and chart backs will be sanitized before reuse. (4)

PERFORMANCE GUIDE

1. Provide surveillance to protect confidentiality of information. the medical record (chart) is the property of the hospital and is maintined for the benefit of the patient, the medical staff, and the hospital. Written consent of the patient is required by the hospital before release of medical information to persons not otherwise authorized to receive this information. Established reasons for charts are: To serve as a basis for patient care, means of communication between physician and other professionals, furnish documentary evidence of the course of illness and treatment, serve as a basis for review, study, and evaluation of patient care, assist in protecting legal interests of patient, hospital and medical staff, and provide data for research. **J.C.A.H.**
2. Provide surveillance to safeguard against defacement, loss, or tampering.
3. Provide surveillance to minimize bacterial and viral contamination.
4. Inspect doctor's order sheets for presence of new orders at periodic intervals during shift. Note: No physician's order should have been written for longer than twenty minutes before it has been discovered and processing of orders begun. Most hospitals have a flagging or chart placement system for physicians to use when writing orders, but the system occasionally breaks down for any number of reasons.
5. Place charts in racks after use by others.
6. Thin charts as needed, store safely, and return pages to chart on discharge. Remove all labels and flags from chart backs upon discharge, or when no longer needed.

LEARNING ACTIVITIES

1. Listen to a panel of medical facility personnel (i.e., a physician, nurse, therapist, attorney for the facility as moderator) discuss the breadth and scope of "Ethics in Communication - Protecting the Confidentiality of Patient Records."
2. Investigate the rules of the local health care facility for ensuring the confidentiality of material in the charts. (Note: attached two samples of governing information.)
3. Discuss ways in which surveillance can be provided to safeguard against defacement, loss, or tampering of charts.

4. Discuss ways in which surveillance can be provided to minimize bacterial and viral contamination of charts.
5. Interview an experienced ward clerk to discover the system he/she uses to note presence of new orders during shift.
6. Discuss procedures to be followed in "thinning" charts.
7. In small buzz groups, each of which is moderated by an experienced ward clerk, read and react to each item listed on the attached information sheet titled "General Guidelines for Ensuring Confidentiality of Patient Charts."
8. Under the supervision of an experienced ward clerk, perform the task of enforcing regulations governing care of patient charts for one shift. The instructor will evaluate the performance. A rating of "fully accomplished" must be achieved.

RESOURCES

panel: physician, nurse, therapist, attorney
experienced ward clerk

TOOLS AND EQUIPMENT

patient charts

EVALUATION

Using standard policies, the student will enforce regulations governing care of charts for one shift. A rating of "fully accomplished" must be achieved, based on the assessment of the instructor.

TO: Ward Clerks
Ward Managers
Evening Administrators

FROM: Ward Clerk Coordinator

DATE: April 19, 1983

SUBJECT: Copying a Patient's Chart

1. A doctor's order must be written on the Physician's Order Sheet in the chart.
2. Have "Authorization for Release of Medical Information" signed by the patient prior to copying.
3. Duplication of any part of the patient's chart is done by the Medical Records Department up until 9:00 PM, Monday through Friday.
4. Contact the P.M. Administrator or Night Nursing Supervisor when Medical Records is closed.
5. No original part of the patient's chart is discarded under any circumstance.
6. The physician should write an order for the parts of the chart to copy.
7. Chart forms that necessarily would not have to be copied (unless the physicin requests specifically) are the graphics, nurses' notes, profile, and surgery forms.

V-TECS 85
L.A. #2

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

DATE______________________________

Permission is hereby given the authorities of the ____________________________ Hospital, , South Carolina

Name____

Street______________________________________

City____

or representative, any and all information in respect to any sickness or injury, including the nature of such physical illness or injury, medical history, consultations, prescriptions, x-rays, copies of hospital or other medical records or charges for service with respect to any illness or injury.

The injury or illness for which this authorization is granted are those resulting from an accident, injury or hospitalization to

Name____

Address_____________________________________

Dates of Admissions__________________________

WITNESS

____

____

SIGNED______________________________
(Patient or Authorized Person)

____
Relationship

GENERAL GUIDELINES FOR ENSURING CONFIDENTIALITY OF PATIENT CHARTS

Know where all patients' charts are at all times.

Keep patients' charts at the nurses' station; do not send them to other departments without permission.

Insist that all persons seeking access to the charts identify themselves and explain their need to see the information. Refer to hospital administration any requests by the patient, lawyers, or insurance investigators to have access to a chart.

Never allow anyone to remove patients' charts from the hospital without approval.

V-TECS 85
L.A. #8

STUDENT____________________________

DATE______________________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Enforce regulations governing care of charts.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When enforcing regulations governing care of charts, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Demonstrated procedures for protecting charts and patient information contained in the chart.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

DUTY: MAINTAINING ENVIRONMENTAL SAFETY AND SANITATION

TASK: Replace outdated supplies

PERFORMANCE OBJECTIVE

Given established policy information, one tracheostomy tray, one vial of regular insulin, and Kardexed dates of two in-use drainage bags: inspect expiration dates and replace according to the posted policies. No outdated supplies will remain on the unit for use. (4)

PERFORMANCE GUIDE

1. Interpret the hospital policy governing dated materials: central supply items, water carafes, drainage bags, medications. Note: Many regulatory bodies govern hospital policies which, in turn, govern these activities.
2. Receive outdated drugs from nurse; return them to pharmacy and obtain replacement.
3. Inspect all dated CSR trays and equipment; return out-dated material to CSR, even if unused, and obtain replacement.
4. Inspect dates on all in-use water carafes; replace every 48 hours.
5. Inspect Kardexed dates of drainage bags applied and provide replacements every seven days.*

* South Carolina writing team suggests that fresh supply of drainage bags should be provided daily.

LEARNING ACTIVITIES

1. Discuss the policy of the local hospital for governing dated materials.
2. Listen to resource speaker (pharmacist) discuss the reason for citing expiration dates on medications (i.e., the ramifications if outdated drugs are used).
3. Visit a unit to observe how one finds a date for a supply item.
4. Research and report in writing the reason(s) for replacing water carafes every 48 hours.
5. Discuss the method to be followed at the local health care facility in returning outdated materials and obtaining replacements.
6. In a mock hospital setting, perform the task of inspecting expiration dates and replacing items as needed. Verbally explain, step-by-step, the procedure being followed. Based on an evaluation by the instructor, the performance must warrant a rating of "fully accomplished."

RESOURCES

pharmacist

TOOLS AND EQUIPMENT

tracheostomy tray
vial of regular insulin
patient care form (or Kardex)

EVALUATION

Using information and materials (i.e., tracheostomy tray, vial of regular insulin, Kardexed dates of two in-use drainage bags), the student will inspect expiration dates and replace items as needed. The preformance must warrant a rating of "fully accomplished," based on the assessment of the instructor.

STUDENT______________________

DATE______________________

INSTRUCTOR'S FINAL CHECKLIST*

Check the student's performance in the skills associated with the following task:

Replace outdated supplies.

Place an X in the appropriate box indicating Not Accomplished, Partially Accomplished, or Fully Accomplished. If, because of special circumstances, the item was impossible to complete, place an X in the Not Applicable Box.

Performance Level: All items must receive a rating of **FULLY ACCOMPLISHED** (or Not Applicable). If any items are rated Not Accomplished or Partially Accomplished, the student and instructor will discuss the situation and decide which learning activities must be repeated. If the instructor chooses to use the checklist as the basis for assigning numerical points, then a separate column and boxes are provided.

When replacing outdated supplies, the student:

	Student Performance				
	Not Applicable	Not Accomplished	Partially Accomplished	Fully Accomplished	Optional: Assigned Points
1. Received outdated supplies; inspected expiration dates; returned items to proper department.	( )	( )	( )	( )	( )
2. Provided replacement for expired items.	( )	( )	( )	( )	( )

---

*Although use of the instructor's final checklist is optional, it is recommended as a valid means for documenting the progress of the student.

SAMPLE

HOSPITAL WARD CLERK EXAMINATION

PART I (50 points)

1. Newly admitted patients will bring from Admitting to the ward three items that are of particular interest to you. Name these items:

.33 1. ______________________________

.33 2. ______________________________

.34 3. ______________________________

2. List the chart forms that make up a patient's basic chart:

.125 1. ____________________
.125 2. ____________________
.125 3. ____________________
.125 4. ____________________

5. ____________________ .12
6. ____________________ .12
7. ____________________ .12
8. ____________________ .12

3. List the additional forms that are necessary when a patient is scheduled for surgery:

.2 1. ____________________
.2 2. ____________________
.2 3. ____________________

4. ____________________ .2
5. ____________________ .2

4. Why are Hospital Ward Clerks so important to the new patients?

____

1.0 ____

____

____

5. When a patient is scheduled for surgery or if a laboratory test needs to be reported by a specific time, how do you convey this message to the Lab?

____

1.0 ____

____

6. What chart form does the Hospital Ward Clerk stamp first, so the Nurse's Assistant can go to the patient's room to admit him/her?______

1.0 ____

7. The Profile Sheet is important because it contains the patient's first

.5 ________________ ________________ which are charted on

the ______________ sheet.

8. Allergies are charted in red on what 3 forms?

.33 1.____

.33 2.____

.34 3.____

9. List some of your responsibilities to the Dietary Department:

.2 1.____

.2 2.____

.2 3.____

.2 4.____

.2 5.____

10. Name two responsibilities that a physician's order may require with a discharge order?

.5 1.______________________________

.5 2.______________________________

11. If you forget to clock in or out on your time card, this would have to be approved by whom?______________________________

1.0 ______________________________

12. When transferring a patient you always notify the following departments:

.16 1.______________ 4.______________ .17

.16 2.______________ 5.______________ .17

.16 3.______________ 6.______________ .17

13. If a situation arose where you needed a nurse at once and he/she was not in the nursing station, where would you look to see what the assignments are?

1.0 ______________________________

14. When a patient requests something for pain over the intercom system, what four things should you do?

.25 1.______________________________

.25 2.______________________________

.25 3.______________________________

.25 4.______________________________

1.0 15. What number do you call for Mayday?______________________________

1.0 16. If a nurse phones the unit and reports that he/she is sick and will not be in today which of the following is the appropriate response?

1. Tell nurse that you hope he/she feels better by tomorrow.

2. Notify the Ward manager.
3. Ask the employee to hold until he/she can speak to the Nurse Clinician.
4. Tell the employee that you will tell the Nurse Clinician.

1.0 17. If you are sick and not able to report to your unit for work, whom do you notify and when?________________________________

____

18. What are your weekly responsibilities to the employees' time cards?

1.0 ____

____

____

____

____

____

____

____

1.0 19. What does "STAT" mean?________________________________

1.0 20. How do you release blood on the crossmatch and administration sheet?

____

21. Diets and intake of diets must be __________ three meals a day on the Graphic sheet. What are the symbols to use?

.166 .166 .167 .167

1.__________ 2.__________ 3.__________ 5.__________

5.__________ 6.__________

.167 .167

22. Correct errors on the graphic sheet (in red) by ______________ the error and ____________________

.50 .50

23. Name at least four (4) tests that have to be scheduled by phone:

.25 1.______________________ .25 3.______________________

.25 2.______________________ .25 4.______________________

24. Upon completion of transcribing a physician's order the order must be ______________________ and the ______________________ written bedside the orders. .50 .50

25. To discontinue an IV additive medication you complete the following three responsibilities.

.33 1.______________________ to notify the __________.

.33 2. Send ______________________ from the ______________
order sheet to the ______________________.

.34 3. Complete a ______________________ ______________________
and send to the pharmacy.

26. My Supervisor is ______________________. Cite your responsibility to him/her.

1.0 27. Do you renew antibiotics or anticoagulant medication?

____

1.0 28. Do you order narcotics?

1.0 29. The correct way to answer the telephone on your ward is?__________

____

1.0 30. Spare time should be applied to benefit you and your ward. What will your Ward Manager find you doing with your spare time that would be helpful?______________________________

____

1.0 31. The appropriate way to correct an error on the Medication Administration Record is to

____

32. If a patient expires and the body goes to the morgue for a post mortum examination, what four forms would be completed and placed on the chart?

.25 1. ____________________________________

.25 2. ____________________________________

.25 3. ____________________________________

.25 4. ____________________________________

33. When you are transcribing medication orders onto the MAR you:

.33 1. Use black ink for the hours between __________ and __________.

.33 2. Use red ink for the hours between __________ and __________.

.33 3. Record __________ in red ink and __________ in black ink.

34. PRN Medication orders are transcribed on the back of the medication administration record with the exception of _______________ (.50) and _______________ (.50) PRN.

35. Give the abbreviations for the following continued medication hours:

.25 9 a.m. ____________________________________

.25 T.I.D. ____________________________________

.25 9 AM - 9 PM ____________________________________

.25 Q.I.D. ____________________________________

36. Give the abbreviations for the following continued medication hours:

.25 Q 12 Hours ____________________________________

.25 Q 6 Hours ____________________________________

.25 5 a.m. 1 p.m. 9 p.m. ____________________________________

.25 B.I.D. ____________________________________

37. Onto what four forms do you transcribe physician's orders?

.25 1. ____________________

.25 2. ____________________

.25 3. ____________________

.25 4. ____________________

38. The following must be completed on a patient's chart, when discharged or transferred:

.1 1. ____________________

.1 2. ____________________

.1 3. ____________________

.1 4. ____________________

.1 5. ____________________

.1 6. ____________________

.1 7. ____________________

.1 8. ____________________

.1 9. ____________________

.1 10. ____________________

39. DEFINE

.1 1. NPO ____________________

.1 2. PRE-OP ____________________

.1 3. POST-OP ____________________

.1 4. PRN ____________________

.1 5. H.S. ____________________

.1 6. A.C. ____________________

.1 7. P.C. ____________________

.1 8. I.M. ____________________

.1 9. I.V.______________________________

.1 10. P.O.______________________________

40. What is the expiration date for Class II and Class III, IV, and V drugs?

1.0 ______________________ ______________________

41. What are the PM Ward Clerk's responsibilities?

.1 1.______________________________

.1 2.______________________________

.1 3.______________________________

.1 4.______________________________

.1 5.______________________________

.1 6.______________________________

.1 7.______________________________

.1 8.______________________________

.1 9.______________________________

.1 10.______________________________

1.0 42. Whom do you notify if you are having problems with other departments?

____

1.0 43. Where do you record all daily admissions, discharges, transfers, and deaths?

____

1.0 44. How do PM Employees get paid?______________________________

____

1.0 45. When a physician tries to give you a phone order, what do you do?

____

1.0 46. When does the Ward Clerk go to the printing room for paper supplies for the ward?______________________________

____

1.0 47. When completing needed information on requisitions, usually there is a place to write the "Pertinent Clinical History"; what would you write as the clinical history and where would you find this information?______________________________

____

____

48. When a patient's chart is returned to the unit from surgery, your responsibilities to this chart would be to:

.25 1.______________________________________

.25 2.______________________________________

.25 3.______________________________________

.25 4.______________________________________

1.0 49. When is the appropriate time to place completed requisitions in the transportation basket or the pneumatic tube system to go to the appropriate departments?

____

____

1.0 50. What was the most interesting part of the Hospital Ward Clerk training classes?

____

____

HOSPITAL WARD CLERK EXAMINATION

PART II (50 points)

1. Chart the following information on the Graphic/Intake-Output record.

1pt a. Date form - Admitting date - 1/11/82.

1pt b. Surgery date - 1/13/82.

		DATE	TIME	T.	P.	R.	TIME	T.	P.	R.
1pt	c.	1/11/82	8 AM	98.6	80	18	4 PM	99.2	60	18
1pt	d.	1/12/82	8 AM	99.0	76	20	4 PM	100.0	72	20
1pt	e.	1/13/82	8 AM	102.4	94	24	4 PM	101.0	80	18
1pt	f.	1/14/82	8 AM	100.2	90	20	4 PM	99.8	94	27
1pt	g.	1/15/82	8 AM	99.2	86	18	4 PM	96.6	70	18
1pt	h.	1/16/82	8 AM	98.8	80	18	4 PM	98.6	72	20
1pt	i.	1/17/82	8 AM	96.6	70	18	4 PM	99.2	80	18

1pt j. Make an error on the graphic section and correct according to health care facility policy.

1pt k. Patient weight 170

1pt l. BP 120/80

1pt m. At 4 PM on 1/11/82 document that the patient voided and had one BM.

1pt n. Change the patient's diet from NPO in Am to surgery liquids at lunch to regular at dinner on the day of surgery.

1pt. o. Document that on 1/11/82 the patient had a regular diet for dinner and ate 3/4 of the meal.

p. What are the abbreviations for the following diets:

1pt 1. Regular ________________ ________________

1pt 2. Soft ________________ ________________

1pt 3. Surgical liquids ________________________

1pt 4. Full liquids ________________________

1pt 5. Bland ______________________________

1pt 6. Low Residue ______________________________

1pt 7. Diabetic ______________________________

1pt 8. Special ______________________________

1pt 9. Nothing by mouth ______________________________

1pt 10. Hold Diet ______________________________

25 pts 2. Transcribe the following physician's orders written on the physician's orders sheet.

South Carolina Department of Education

OFFICE OF VOCATIONAL EDUCATION

HEALTH OCCUPATIONS EDUCATION

hereby certifies that

has satisfactorily completed the course in

at ______________________________ ______________________________ *19*____

____
School Administrator

____
Instructor

____
State Consultant Health Occupations Education

SAMPLE CERTIFICATE OF COMPLETION

A Sample Letter of Acknowledgment to Completers of Training

YOUR JOB AS A HOSPITAL WARD CLERK:

The position of Hospital Ward Clerk is a very busy and important job. You will be answering the intercom and telephone, handling all paperwork, transcribing physicians' orders, making requests for diagnostic procedures and tests. You will usually be the first person to be approached not only by the patients and visitors but also by all other hospital staff and physicians. You will be called on for answers to questions, solutions to complaints and information regarding the care and treatment of patients on your ward.

You may be relied on for such tasks as diet changes and ordering nourishment for the patients on your ward, ordering supplies, admitting, transferring, discharging and handling a patient death.

Additional duties include discontinuing medication and I.V. orders and keeping your desk supplied with chart forms and requisitions from the printing room.

The Lab is a very important part of your job. You will be taking lab test results by phone, charting results on the appropriate lab forms in the charts and releasing blood on the crossmatch and blood administration record. You will be renewing medication orders and flagging charts with isolation and allergy tapes.

After reading this, you must be aware of how important you are to the nurses on your ward and, conversely, you will rely on the nurses for many things.

The key to your success will be the way you perform and how well you keep your ward organized. This depends mainly on you, the Ward Clerk.

Your supervisors, the Ward Managers, will always be very supportive of you if you show interest, come to work dressed professionally and function as a caring adult.

Always be polite and have respect for others. A few kind words like "thank you" can make the differences between a productive shift and a wasted day for the Ward Clerk.

Get on your ward and feel like a member of the health care team and your position will be a very rewarding one!

I enjoyed having you in class and hope you have learned a lot. If at any time you need to talk with me about your job, feel free to call.

Sincerely,

Instructor's Name and Title

ACHIEVEMENT RECORD

The following student

____

is a graduate of

HEALTH OCCUPATIONS EDUCATION
Hospital Ward Clerk

at

____

and

has satisfactorily achieved the COMPETENCIES cited on the subsequent pages.

____________, 19____

____
(Instructor)

____________________(Signature of instructor)

____________________(Date)

ACHIEVEMENT RECORD

HOSPITAL WARD CLERK

COMPETENCIES	Accomplished*	Needs Improvement**	Not Accomplished***
I. PERFORMING RECEPTIONIST ACTIVITIES			
A. Greet and direct professionals, (new patients), and visitors to patient location.			
B. Accept incoming telephone calls and relay messages.			
C. Call physician's answering service or office and relay messages.			
D. Answer pages, page persons.			
E. Accept and direct mail, flowers, gifts.			
F. Arrange special visiting privileges.			
G. Greet physician and provide patients' charts.			
II. PERFORMING CLERICAL ACTIVITIES (INTERNAL COMMUNICATION SYSTEMS)			
A. Initiate and respond to telecom/intercom communications.			
B. Receive and send articles by dumb waiter or pneumatic tube.			
III. PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES			
A. Assemble/disassemble addressograph plate.			
B. Initiate graphic sheet.			
C. Graph temperature, pulse, respiration.			

*Accomplished: Student has demonstrated mastery of the competency by satisfactorily performing in the classroom laboratory and/or clinical setting.

**Needs Improvement: Student has attempted mastery of the competency, but needs additional practice and supervision (preferably during orientation phase of employment).

***Not Accomplished: Student has not demonstrated mastery of the competency. In-depth instruction and practice under supervision are recommended.

BEST COPY AVAILABLE

COMPETENCIES	Accomplished*	Needs Improvement**	Not Accomplished***
D. Chart data from information supplied such as weight, B.P., diet, B.M., I. & O.			
E. Check new patient's allergy record, (Patient History), flag chart and Kardex (appropriate forms).			
F. Prepare medicine sheets (Medication Administration Record {MAR}).			
G. Prepare requisitions for routine diagnostic tests.			
H. Institute/change/discontinue diet service.			
I. Clerically admit patients.			
J. Transcribe admission orders.			
K. Route delayed diagnostic reports of discharged/transferred patients.			
L. Deposit or withdraw patient's money or valuables from safe.			
M. Clerically transfer patients.			
N. Clerically discharge patients.			
O. Instruct patient or family of discharge procedures.			
P. Assemble and check chart for medical records on discharge.			
Q. Prepare credit slip for return of unused medication.			
R. Perform clerical discharge procedure for deceased patient.			
S. Prepare a replacement patient identification band.			
IV. PERFORMING CLERICAL ACTIVITIES			
A. Obtain signatures on consent, against advice, or release forms.			
B. Prepare and maintain TPR and diet worksheet.			
[illegible] Prepare pharmacy requisitions.			
[illegible] Prepare and route X-ray requisitions.			
E. Prepare and route special therapy requisitions.			
F. Obtain X-rays.			
G. Arrange escort and transportation services for therapy elsewhere.			

BEST COPY AVAILABLE

COMPETENCIES	Accomplished*	Needs Improvement**	Not Accomplished***
H. Arrange for ordered consultations.			
I. Discontinue all orders when patient goes to surgery.			
J. Distribute forms and articles from "in" basket.			
K. Execute pre-op chart check.			
L. Prepare laboratory requisition form(s).			
M. Place/remove special bedside directives.			
N. Prepare and route medication index forms.			
O. Inspect and report expiring narcotic or antibiotic orders.			
P. Photocopy chart forms.			
Q. Prepare addressographed nurses' notes sheets for each patient.			
V. PERFORMING MANAGERIAL ACTIVITIES			
A. Locate assistants for therapists and technicians.			
B. Brief oncoming ward clerk.			
C. Dispense and charge supplies.			
D. Check and route patient food trays.			
E. Initiate codes upon nurses' directives.			
F. Initiate and route incident or accident reports.			
G. Prepare and route report forms.			
H. Arrange maintenance and repair of equipment.			
I. Prepare and maintain a laboratory and X-ray "Hold Diet" sheet.			
J. Prepare a supply of assembled packets for admission, surgery, discharges.			
K. Maintain inventories of supplies and equipment.			
L. Trace lost and found articles.			
M. Obtain and charge special equipment.			
N. Provide orientation to newly employed workers.			
O. Prepare and route supply requisitions.			

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COMPETENCIES	Accomplished*	Needs Improvement**	Not Accomplished***
P. Assist in supervision of ward clerk students.			
Q. Refer patient complaints or problems to a corrective department.			
R. Receive and store supplies and equipment.			
S. Schedule patient treatments or therapy with other hospital departments.			
T. Select and mark needed special hour TPR's on worksheet (graphic sheet).			
U. Trace missing lab specimen or reports.			
VI. PERFORMING RECORD KEEPING ACTIVITIES			
A. Prepare and maintain daily census sheet.			
B. Add chart forms as needed.			
C. Obtain and safeguard prior admission chart.			
D. Post all diagnostic reports on charts.			
E. Prepare and add supplemental forms to charts such as diabetic record, coagulation record, physical therapy record, etc.			
F. Prepare, maintain, and post/route lists.			
VII. MAINTAINING ENVIRONMENTAL SAFETY AND SANITATION			
A. Prepare for ordered isolation care.			
B. Plan/execute nursing station sanitizing.			
C. Enforce regulations governing care of charts.			
D. Replace outdated supplies.			

SECTION THREE: Appendices

TASK LIST AND JOB TITLES

Sequenced Tasks	V-TECS Objective	WARD CLERK (Medical Services) D.O.T. #219-388-286
Unit I PERFORMING RECEPTIONIST ACTIVITIES		
1. Greet and direct professionals, (new patients), and visitors to patient location.	#6/16	X
2. Accept incoming telephone calls and relay messages.	#2/19	X
3. Call physician's answering service or office and relay messages.	#5/23	X
4. Answer pages, page persons.	#3/26	X
5. Accept and direct mail, flowers, gifts.	#1/30	X
6. Arrange special visiting privileges.	#4/38	X
7. Greet physician and provide patients' charts.	#7/45	X
Unit II PERFORMING CLERICAL ACTIVITIES (INTERNAL COMMUNICATION SYSTEMS)		
1. Initiate and respond to telecom/intercom communications.	#53/47	X
2. Receive and send articles by dumb waiter or pneumatic tube.	#75/81	X
Unit III PERFORMING ADMISSION, TRANSFER, AND DISCHARGE ACTIVITIES		
1. Assemble/disassemble addressograph plate.	#36/85	X
2. Initiate graphic sheet.	#40/88	X
3. Graph temperature, pulse, respiration.	#77/94	X
4. Chart data from information supplied such as weight, B.P., diet, B.M., I. & O.	#76/100	X
5. Check new patient's allergy record, (Patient History), flag chart and Kardex (appropriate forms).	#37/104	X
6. Prepare medicine sheets ...{Medication Administration Record}...	#50/113	X
7. Prepare requisitions for routine diagnostic tests.	#51/124	X
8. Institute/change/discontinue diet service.	#41/130	X
9. Clerically admit patients.	#47/134	X
10. Transcribe admission orders.	#45/176	X
11. Route delayed diagnostic reports of discharged/transferred patients.	#52/182	X

Unit III (cont'd.)

12. Deposit or withdraw patient's money or valuables from safe.	#39/185	X
13. Clerically transfer patients.	#38/188	X
14. Clerically discharge patients.	#48/197	X
15. Instruct patient or family of discharge procedures.	#42/209	X
16. Assemble and check chart for medical records on discharge.	#35/212	X
17. Prepare credit slip for return of unused medication.	#43/219	X
18. Perform clerical discharge procedure for deceased patient.	#44/229	X
19. Prepare a replacement patient identification band.	#46/242	X

Unit IV PERFORMING CLERICAL ACTIVITIES

1. Obtain signatures on consent, against advice, or release forms.	#66/245	X
2. Prepare and maintain TPR and diet worksheet.	#70/255	X
3. Prepare pharmacy requisitions.	#72/262	X
4. Prepare and route X-ray requisitions.	#74/269	X
5. Prepare and route special therapy requisitions.	#73/273	X
6. Obtain X-rays.	#67/286	X
7. Arrange escort and transportation services for therapy elsewhere.	#54/289	X
8. Arrange for ordered consultations.	#55/296	X
9. Discontinue all orders when patient goes to surgery.	#57/299	X
10. Distribute forms and articles from "in" basket.	#58/302	X
11. Execute pre-op chart check.	#59/305	X
12. Prepare laboratory requisitions form(s).	#61/316	X
13. Place/remove special bedside directives.	#62/329	X
14. Prepare and route medication index forms.	#63/335	X
15. Inspect and report expiring narcotic or antibiotic orders.	#65/346	X
16. Photocopy chart forms.	#68/351	X
17. Prepare addressographed nurses' notes sheets for each patient.	#69/355	X

Unit V PERFORMING MANAGERIAL ACTIVITIES

1. Locate assistants for therapists and technicians.	#13/360	X

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Unit V (cont'd.)

2.	Brief oncoming ward clerk.	#14/365	X
3.	Dispense and charge supplies.	#15/368	X
4.	Check and route patient food trays.	#16/372	X
5.	Initiate codes upon nurses' directives.	#17/376	X
6.	Initiate and route incident or accident reports.	#18/381	X
7.	Prepare and route report forms.	#19/386	X
8.	Arrange maintenance and repair of equipment.	#20/388	X
9.	Prepare and maintain a laboratory and X-ray "Hold Diet" sheet.	#21/391	X
10.	Prepare a supply of assembled packets for admission, surgery, discharges.	#22/398	X
11.	Maintain inventories of supplies and equipment.	#23/404	X
12.	Trace lost and found articles.	#24/407	X
13.	Obtain and charge special equipment.	#25/410	X
14.	Provide orientation to newly employed workers.	#26/414	X
15.	Prepare and route supply requisitions.	#27/417	X
16.	Assist in supervision of ward clerk students.	#28/420	X
17.	Refer patient complaints or problems to a corrective department.	#29/423	X
18.	Receive and store supplies and equipment.	#30/426	X
19.	Schedule patient treatments or therapy with other hospital departments.	#31/428	X
20.	Select and mark needed special hour TPR's on work sheet (graphic sheet).	#32/435	X
21.	Trace missing lab specimen or reports.	#33/441	X

Unit VI PERFORMING RECORD KEEPING ACTIVITIES

1.	Prepare and maintain daily census sheet.	#82/444	X
2.	Add chart forms as needed.	#78/452	X
3.	Obtain and safeguard prior admission chart.	#79/455	X
4.	Post all diagnostic reports on charts.	#80/458	
5.	Prepare and add supplemental forms to charts such as diabetic record, coagulation record, physical therapy record, etc.	#81/461	X
6.	Prepare, maintain, and post/route lists.	#8/465	X

Unit VII MAINTAINING ENVIRONMENTAL SAFETY AND SANITATION

1.	Prepare for ordered isolation care.	#83/468	X
2.	Plan/execute nursing station sanitizing.	#84/471	X
3.	Enforce regulations governing care of charts.	#85/474	X
4.	Replace outdated supplies.	#86/480	X

Appendix B

DEFINITION OF TERMS

The following terms are supplied to establish operational definitions as they apply to this study.

Career Ladder. A vertical arrangement of jobs within an occupational area to indicate skill distinction and progression.

Catalogs. A comprehensive collection of performance objectives, performance guides, criterion-referenced measures, and related data organized by a job structure or career ladder within a domain of interest.

Consortium. A group of state agencies, institutions, or other entities which have been legally constituted through letters of commitment, agreements, or by assignment of higher authorities to work together toward the solution of problems in education. A membership from autonomous agencies and institutions which cut across state boundaries as they attempt to solve problems or meet goals.

D.O.T. Code. A nine-digit number used to identify a specific job within a given domain.

Instructional System Development (ISD). A deliberate orderly process for planning and developing instructional programs which insure that personnel are taught the knowledges, skills, and attitudes essential for successful job performance. Depends on a desception and analysis of the tasks necessary whether or not the objectives have been reached, and methods for revising the process based on empirical data.

Occupational Inventory (Task Inventory Booklet). A survey instrument containing tasks performed by job incumbents within D.O.T.'s complete with background information and a list of tools and equipment.

Performance-Based Instruction. Instruction which, when properly designed and applied, results in the learner's demonstration of certain abilities. The desired abilities are selected before the instruction is designed and are clearly defined as observable performance objectives. In V-TECS catalogs, the abilities are primarily psychomotor. This type of instruction is also referred to as competency-based instruction.

Performance Guide (PG). A series of steps, arranged in a sequence ordinarily followed, which when completed may result in the performance of a task. Also, called "teaching steps."

Project. An occupational domain area selected by a V-TECS member state for catalog, development based upon the U.S. Department of Labor's Dictionary of Occupational Titles (D.O.T.).

State-of-the-Art (SOA Study). Research conducted to determine the current status of performance-based instructional materials and practices in the domain area under study and to obtain other information that might be useful in catalog development.

Task. A unit of work activity which constitutes logical and necessary steps in the performance of a duty. A task has a definite beginning and ending point in its accomplishments and generally consists of two or more definite steps.

Task Analysis. A characteristic of a task statement which makes its accomplishments crucial to the acceptable performance of a worker or student. A method of analysis which identified the critical tasks and aids in determining the consequence of poor performance or lack of performance by a worker or student.

Writing Team. A team of people representing instructors within subject matter expertise, persons having knowledge and experience in developing criterion-referenced measures, local or state supervisors of incumbent workers whose function is to analyze occupational data and develop performance objectives and criterion-referenced measures for specific D.O.T. areas.

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TOOL AND EQUIPMENT LIST

EQUIPMENT NUMBER	EQUIPMENT DESCRIPTION	PERCENTAGE OF MEMBERS USING*	NUMBER OF MEMBERS USING
106	Culture and sensitivity requisition forms	100	151
37	Graphic chart forms	99	150
122	Urinanalysis requisition forms	99	150
147	Telephone	99	150
18	Charts	99	149
74	Kardex	99	149
109	E.K.G. requisition forms	99	149
113	Hematology requisition forms	99	149
123	X-ray requisition forms	99	149
36	Doctor's order chart forms	98	148
115	Inhalation therapy requisition forms	97	146
49	Vital signs record chart forms	96	145
103	Central supply requisition forms	96	145
121	Transfer and discharge requisition forms	96	145
62	Desk	95	144
104	Chemistry requisition forms	94	144
33	Consultation request and report of chart forms	95	143
41	Laboratory reports chart forms	95	143
142	Stapler - hand	95	143
29	Admission notes chart forms	94	142
16	Bulletin board	93	141
87	Blood bank requisition printed forms	93	141
22	Allergy chart flags	93	140
51	Operative consent forms	93	140
20	Chart dividers	92	139
21	Clip board	91	138
126	Floor supplies requisition pads	91	138
2	Addressograph plate	91	137
8	Hospital procedure manual	91	137
44	Nurses notes chart forms	91	137
94	Pre-op check list printed forms	91	137
118	Physical therapy and orthopedic services requisition form	90	136
102	Bacteriology requisition forms	89	135
132	Scissors	89	135
12	Medical dictionary	89	134
34	Diabetic record chart forms	89	134
38	History chart forms	89	134
11	Physician's Desk reference book	88	133
19	Chart backs	88	133
47	Progress notes chart forms	88	133
73	Intercom	88	133
107	Cytology requisition forms	88	133
120	Serum enzymes requisition forms	88	133
116	IV solution requisition forms	87	132

*All percentages have been rounded out to the nearest whole number.

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TOOL AND EQUIPMENT LIST

EQUIPMENT NUMBER	EQUIPMENT DESCRIPTION	PERCENTAGE OF MEMBERS USING*	NUMBER OF MEMBERS USING
83	Office supplies	86	130
90	Incident report printed forms	86	130
137	N.P.O. signs, special	86	130
76	Chart, color coded-physician labels	85	129
42	Medicine sheets chart forms	85	128
43	Nursing admission record chart forms	85	128
71	Identification bands	85	128
108	E.E.G. requisition forms	85	128
130	Ruler	85	128
7	Hospital policy manual	84	127
40	Intake and output - daily chart forms	84	127
48	Release form chart forms	84	127
135	Isolation signs, special	84	127
75	Bed	83	125
3	Addressograph machine imprinter	82	124
129	Office supplies requisition pads	82	124
6	Hospital disaster manual	80	121
139	I. and O. signs, special	80	121
117	Nuclear medicine requisition forms	79	120
24	Color coded physician's chart flags	79	119
46	Physical chart forms	79	119
124	Dietary supplies requisition pads	79	119
134	Hold breakfast signs, special	77	117
136	No visitors signs, special	77	117
30	Admission summary sheet chart forms	77	116
39	Intake and output - cumulative chart forms	77	115
53	Chart racks carrousel	77	115
105	Credit requisition forms	77	116
13	Ward clerk procedure manual	76	115
52	Against advice consent forms	75	113
86	Assignment sheets printed forms	74	112
31	Anaesthesia record chart forms	74	111
35	Discharge summary sheet	73	110
95	Prescription blanks printed forms	73	110
138	Oxygen-in-use signs, special	73	110
45	O.R. record chart forms	69	104
58	Xerox copy machine	69	104
143	Staple remover	68	102
92	Nursing care plan printed forms	67	101
81	Medicine tickets O color coded	62	94
91	Infection report printed forms	60	91
32	Coagulation record chart forms	59	89
78	Room	58	88
28	Reorder narcotics chart flags	58	87
27	Reorder antibiotics chart flags	57	86
79	Patients' belongings labels	57	86

*All percentages have been rounded out to the nearest whole number.

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TOOL AND EQUIPMENT LIST

EQUIPMENT NUMBER	EQUIPMENT DESCRIPTION	PERCENTAGE OF MEMBERS USING	NUMBER OF MEMBERS USING
93	Patient roster printed forms	56	85
50	Diagnostic consent forms	54	82
99	Time sheet printed forms	54	81
133	Activity signs, special	53	80
119	Radioisotopes requisition forms	52	78
84	Paper punch	51	77
77	Medicine drawer labels	50	76
69	Filing equipment card files	50	75
72	Identification cards	49	74
68	File, rotary - telephone numbers	47	71
148	Telephone Multi-Line Phone	47	71
125	Drug supplies requisition pads	46	70
26	Recertify Medicare chart flags	45	68
88	Drug credit list printed forms	44	67
145	Tape measure	44	67
128	Medical-surgical requisition pads	44	66
9	Merck manual	43	65
97	Report sheets printed forms	43	65
101	Public address system	42	65
63	Dressing tray	42	63
153	Tricolor pen	42	63
112	General Service requisition forms	40	61
59	Crash cart	40	60
61	Date stamp	36	55
151	Thermometer	34	51
89	Home care instructions printed forms	33	50
110	E.M.G. requisition forms	33	50
144	Stethoscope	33	50
25	Recertify Medicaid chart forms	32	48
64	Dumb waiter	31	47
152	Time stamp machine	31	47
141	Spindles - desk	30	46
159	Watch with second hand	30	45
127	Housekeeping supplies requisition pads	27	41
100	Utilization report sheet printed forms	27	40
10	National Formulary Book	24	36
23	Color-coded nursing care chart flags	24	36
140	Sphygomanometer	23	34
1	Addressograph bar	21	32
98	Team treatment printed forms	21	32
80	Lamps, gooseneck	21	31
111	E.M.I. requisition forms	19	29
114	Hemodialysis requisition forms	15	23
85	Physical exam tray	13	21
157	Pneumatic tubes	13	21
149	Telecom console	13	19
146	Tape recorder	12	18

*All percentages have been rounded out to the nearest whole number.

TOOL AND EQUIPMENT LIST

EQUIPMENT NUMBER	EQUIPMENT DESCRIPTION	PERCENTAGE OF MEMBERS USING*	NUMBER OF MEMBERS USING
5	Auto clave tape	9	14
67	File - rotary, equipment	9	14
158	Lamson tubes	9	14
96	Quality control printed forms	8	12
154	Typewriter	8	12
54	Computer terminals	7	10
56	Mimeograph copy machines	7	10
15	Brewer plate	6	9
82	Microfilm or microfiche reader	6	9
131	Safe combination	5	7
66	Embossing equipment	3	5
156	Transitube	3	5
4	Addressograph typewriter	3	4
17	Cash box	3	4
60	Data processing machine	3	4
65	Electrowriter	3	4
14	Brewer bar	1	2
155	Typewriter for metal plates - Brewer	1	2
160	Paper cutter	1	4
161	E.K.G. strip machine	1	2
150	Teletype machine	1	1
162	Label maker	1	1
55	Ditto copy machine	0	0
57	Thermofax copy machine	0	0

*All percentages have been rounded out to the nearest whole number.

ADDITIONS TO TOOL AND EQUIPMENT LIST
(identified by South Carolina writing team)

Catheter irrigation set
Census forms
Code plan
Printed hypothetical situation for emergency code
Projector, film
Tape player
Tracheostomy tray

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6. **Hospital Unit Secretary.** Published for Hospital Research and Educational Trust by Robert J. Brady Company, Bowie, Maryland, 1984

AUDIO-VISUALS

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Medical University of South Carolina, Division of Continuing Education and Health. Charleston, South Carolina

"Introduction to the Ward Unit Secretary" film (1973)
Train-Aide Educational System by Pharmaseal. Glendale, California

"Pneumatic Tube System"
(MccPowers Trans Logic 200/300 Training Film) Trans Logic Company
Denver, Colorado

"The Telephone Dimension System" film (1981)
Southern Bell. Columbia, South Carolina

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SUBJECT MATTER REFERENCES USED IN OTHER V-TECS STATES

All states in the consortium were surveyed. The following list reflects the results of the survey.

Alabama

(programs taught in clusters in Alabama) For information contact: Dr. Myra LeFleur, Maricopa Technical College, 108 N 40th Street
Phoenix, Arizona 85034

Florida

No references

Georgia

No references

Illinois

No references

Kentucky

No response

Maryland

No response

Pennsylvania

No response

Virginia

Virginia Department of Education and Virginia Polytechnic Institute and State University. (B. June Schmidt, Project Director). **INSTRUCTIONAL RESOURCE GUIDE FOR COMPETENCY-BASED EDUCATION IN MEDICAL OFFICE PROCEDURES.** September 1982

West Virginia

No references

SUPPLEMENT

This supplement is included in order to provide blank sample forms commonly used by hospital ward clerks. The instructor will decide whether 1) to use some or all of the attached sample forms, 2) to secure appropriate forms from an affiliating local health care facility, or 3) to compose original forms, based on information found in textbooks, etc.

The following forms are currently being used by the Baptist Medical Center at Columbia, South Carolina.

LISTING OF BLANK SAMPLE FORMS

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Medication Administration Record . . . 519

Schedule for Patient Treatment . . . 521

Patient Treatment Flowcard . . . 523

Pre-operative Check List . . . 524

Graphic/Intake-Output Record . . . 526

Twenty-Four Hour Record of T, P, R, & B.P. . . . 528

Patient Transfer Form . . . 529

Daily Unit Assignment Sheet . . . 530

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Triplicate Forms and Report Sheets

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All Entries Must Be Printed

Medication Administration Record

Enter Here IN PENCIL Number of Forms in Use ☐

Name

Case No.

Room No.

Diagnosis ________________

Surgery ________________

Allergie Test (Record in Red) ________________

DATES GIVEN

Form No. 30

OR Date Initials	Exp. Date Time	Medication—Dosage—Rt. of Adm.	HR.														

SINGLE ORDERS – PRE-OPERATIVES

Enter here in pencil No. of Forms in use ☐

OR Date Initials	Medication — Dosage — Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial	OR Date Initials	Medication — Dosage — Frequency — Rt. of Adm.	To Be Given Date	To Be Given Time	Nurse Initial

(PRN ORDERS – SEE REVERSE SIDE)

Doctor ____________ Intern ____________ Date/Time Admitted ____________

Age ______ Religion ____________ Date/Time Discharged ____________

Name ____________

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SIGNATURE	**TITLE**	**SIGNATURE**	**TITL.**

PRN Medications

Nurse giving a PRN medication enters, next to the medication, vertically, the date – time given and initials for each dose given.

Dr Date Initials	Exp. Date Time	Medication — Dosage — Frequency — Rt. of Adm.	DOSES GIVEN

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SCHEDULE FOR PATIENT TREATMENT

Definition and Purpose: The Schedule for Patient Treatment form which facilitates communication of patients' whereabouts to nursing personnel regarding schedule for treatment/test by other departments.

Responsible Person: To be completed by the PM Unit Secretary.

1. Complete during PM shift.
2. Complete the date, department/unit,
3. List the patient's room, initial and last name.
4. Check surgery column if the patient is scheduled for surgery.
5. Write the time in R.R., when R.R. calls to notify unit.
6. Write the name of lab test in laboratory column.
7. Write the name of X-ray examination requested in X ray column.
8. Make a check in all other departments when a patient is scheduled for examination or treatment.
9. Chart column - write the appropriate yes/no if chart taken.
10. Initial column: completed by transportation - the person taking patient for treatment/test.
11. Time In/Time Out completed by transportation. (In pencil)
12. Flowcard taped to chart and department or departments circled by P.M. Unit Secretary at the time she completes the treatment sheet.
13. Department responsible for notifying unit if patient is sent to another department. Unit Secretary writes in the time of notification under the appropriate department in pencil.
14. Erase the time in and out if a patient has to return to a department the second time then write in the time notified by the department.
15. Department responsible for notifying unit when it's necessary for a patient to go from one department to another. The unit secretary writes in the time in "time column" in pencil.
16. Transportation to erase the time (In/Out) under appropriate department column when it's necessary for a patient to go to a department the second time to complete a treatment/test.
17. Shaded area under each patient's name, room #, may be used for N.P.O., Hold breakfast & etc.
18. Each time a patient is delivered to a department, Transportation should state, "This patient is from ________________" (example, "Third Whiteside, Sixth Long, etc." OR "X-Ray, EKG, Physical Therapy, etc."

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Schedule For Patient Treatment

ATE ____________ DEPARTMENT ____________ UNIT ____________

ROOM #	PATIENT NAME	Surg.	R.R. Time	Laboratory	X-Ray	Nuc. Med	C.T. Scan	Ultra Sound	Rad. Ther	Resp Ther	Phys Ther	E E G E K G	G I Lab	Chart	Init.
	Time Out Time In														

NOTE: Tape a Flow Card on the Patient's chart and circle the appropriate Department(s) at the time you complete the Patient's Treatment Sheet.

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*PATIENT TREATMENT FLOWCARD

Date _____ Patient ____________________

	Time Scheduled if Known	Time Completed	Floor Called
G.I. Lab			
X-Ray			
Nuclear Med.			
C.T. Scan			
Ultrasound			
Rad. Therapy			
Resp. Therapy			
Physical Therapy			
EKG/EEG			
Other			

*Circle all departments the patient is scheduled to visit and tape this card to the front of the chart.

PRE-OPERATIVE CHECK LIST **Nurse's Initials**

1. Operative permit signed and properly witnessed.
2. CBC on chart.
3. Urinalysis on chart.
4. Physician notified of abnormal lab/x-ray reports.
5. Bleeding and coagulation time on chart of T&A patient, (if ordered).
6. Blood typed and crossmatched. Yes ____ No ____ Units
7. History and physical exam on chart ____ or dictated
8. Notify PM Administrator if H&P not on chart by 9 p.m.
9. Consultation sheet signed and on chart as required by hospital policy.
10. Special permits signed and properly witnessed as required by hospital policy.
11. Religion of patient is
12. Anesthesia sheet on chart.
13. Pre-op teaching done. Peds party ____ GYN class ____ Individual ____
    Date ____ PM/Night Nurse's Signature
14. Identification bracelet on and legible
15. TPR and BP are charted.
16. Cosmetics, hairpins, hairpieces, wigs, artificial eyelashes removed.
17. Dentures ____ Partial Plates ____ Bridges ____ Caps ____
18. Contact lens Yes ____ No ____ Placed
19. Mouth checked for chewing gum, mints, etc.
20. Jewelry Yes ____ No ____ Placed
21. Complete recheck of doctor's pre-operative orders.
22. Addressograph plate with chart.
23. MAR on chart.
24. Patient care form on chart.

84-34

Nurse's Initials

25. Urinary bladder emptied ___ Catheter inserted ___

26. All nail polish removed from nails ___

27. Re-check operative permit prior to pre-op being given. ___

Date ___ Night/AM Nurse's Signature ___

OR-HOLDING ROOM

28. Patient received in Holding Room at am/pm ___

29. Shave completed by ___

30. Chart checked by ___ and ___

Holding Room Personnel Circulating Nurse

GRAPHIC/INTAKE - OUTPUT RECORD

DATE																																										
HOSP DAY/PO-PP																																										
HOUR		A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.	
		12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4
CHART PULSE IN RED	CHART TEMPERATURE IN BLUE																																									
140	105																																									
130	104																																									
120	103																																									
110	102																																									
100	101																																									
90	100																																									
80	99																																									
	Normal																																									
70	98																																									
60	97																																									
50	96																																									
RESPIRATIONS																																										
WEIGHT																																										

DATE		INTAKE					OUTPUT			
TIME	MOUTH	PARENTERAL			TOTAL	URINE				TOTA
10 – 6										
6 – 2										
2–10										
24 HR. TOTAL										

		INTAKE					OUTPUT			
TIME	MOUTH	PARENTERAL			TOTAL	URINE				TOTA
10 – 6										
6 – 2										
2–10										
24 HR. TOTAL										

		INTAKE					OUTPUT			
TIME	MOUTH	PARENTERAL			TOTAL	URINE				TOTA
10 – 6										
6 – 2										
2–10										
24 HR										

BEST COPY AVAILABLE

	INTAKE					OUTPUT				
TIME	MOUTH	PARENTERAL			TOTAL	URINE				TOTA
10 – 6										
6 – 2										
2–10										
24 HR. TOTAL										

	INTAKE					OUTPUT				
TIME	MOUTH	PARENTERAL			TOTAL	URINE				TOTA
10 – 6										
6 – 2										
2–10										
24 HR. TOTAL										

	INTAKE					OUTPUT				
TIME	MOUTH	PARENTERAL			TOTAL	URINE				TOTA
10 – 6										
6 – 2										
2–10										
24 HR. TOTAL										

	INTAKE					OUTPUT				
TIME	MOUTH	PARENTERAL			TOTAL	URINE				TOTA
10 – 6										
6 – 2										
2–10										
24 HR. TOTAL										

TWENTY-FOUR HOUR RECORD OF T, P, R, & BP
(Weight & Elimination)

		12 m.n.		4 a.m.		8 a.m.		12 noon		4 p.m.				8 p.m.	
PATIENT NAME	WT	T, P, R	BP	T, P, R	BP	T, P, R	BP	T, P, R	BP	T, P, R	BP	U	S	T, P, R	BP

BMCC 3/84

PATIENT TRANSFER FORM
(INTER-AGENCY REFERRAL)

1. PATIENT'S LAST NAME | FIRST NAME | MI | 2. SEX | 3. HEALTH INSURANCE CLAIM NUMBER

4. PATIENT'S ADDRESS (Street number, City, State, Zip Code) | 5. DATE OF BIRTH | 6. RELIGION

7. DATE OF THIS TRANSFER | 8. FACILITY NAME AND ADDRESS TRANSFERRING TO

9. Dates of qualifying stay FROM | THRU

10-A. FACILITY NAME AND ADDRESS TRANSFERRING FROM

10-B. QUALIFYING AND OTHER PRIOR STAY INFORMATION (Including Medical Record Numbers)

EMPLOYMENT RELATED ☐ YES ☐ NO | MEDICAID ELIGIBLE ☐ YES ☐ NO

11. INSURING ORGANIZATION OR STATE AGENCY NAME AND ADDRESS | 12. POLICY OR MEDICAL ASSISTANCE NO

13. SOCIAL SECURITY NUMBER | 14. DATE OF LAST PHYSICAL EXAMINATION

ATTENDING PHYSICIAN EVALUATION

1. NAME AND ADDRESS OF PHYSICIAN AT NEW FACILITY

2. FINAL DIAGNOSIS(ES), OR PHOTOCOPY ATTACHED ☐

PRIMARY:

ALL OTHER CONDITIONS:

3. SURGICAL PROCEDURE(S) AND DATE(S) OR, CHECK NONE ☐

4. PHYSICIAN ORDERS ON TRANSFER:

5. ESTIMATED MEDICALLY NECESSARY STAY:

_______ DAYS _________ WEEKS OR _______ MONTHS

6. REHABILITATION POTENTIAL:

7. DIETARY REGIMEN:

8. PHYSICIAN'S SIGNATURE | DATE

NURSING EVALUATION

1. SPEECH	Normal ☐	Impaired ☐	Unable To Speak
2. HEARING	Normal ☐	Impaired ☐	Deaf
3. SIGHT	Normal ☐	Impaired ☐	Blind
4. MENTAL STATUS	Always Alert ☐	Occasionally Confused ☐	Always Confused
5. DENTURES	Upper ☐	Lower ☐	Other ______
6. FEEDING	Independent ☐	Help with Feeding ☐	Cannot Feed Self
7. APPETITE	Good ☐	Fair ☐	Poor
8. DRESSING	Independent ☐	Help with Dressing ☐	Cannot Dress Self
9. ELIMINATION	Independent ☐	Help to Bath Rm. ☐ Bedpan or Urinal Req. ☐	Incontinent
10. BOWEL PATTERN	______	Last BM ______	Home Remedies ______
11. BLADDER: FOLEY ☐			
12. BATHING	Independent ☐	Bathing with help ☐ Bed bath with help ☐	Bed Bath
13. MOBILITY	Independent ☐	Walks with Assistance ☐ Help from bed to Chair ☐	Bed Bound

14. DRUG ALLERGIES

15. LEVEL OF CARE

16. DRESSINGS AND BANDAGES, OR CHECK NONE ☐

17. APPLIANCES OR SUPPORTS, OR CHECK NONE ☐

18. NURSING ASSESSMENT AND RECOMMENDATIONS

SUMMARY ATTACHED ☐ YES ☐ NO

19. SIGNATURE | TITLE | DATE

SOCIAL EVALUATION

1. NAME AND ADDRESS OF PERSON TO CONTACT | RELATIONSHIP TO PATIENT | TELEPHONE NUMBER

2. PATIENT LIVES:

ALONE ☐ WITH FAMILY ☐ WITH SPOUSE ☐ OTHER ☐ EXPLAIN

3. SOCIAL SERVICES ASSESSMENT

4. SIGNATURE | DATE | TITLE

BEST COPY AVAILABLE

Date

DAILY UNIT ASSIGNMENT SHEET

Shift

Charge Nurse
Break:
Meal:

Ward Clerk
Break:
Meal:

Group I
Rooms

Leader:
Meeting:
Break
Meal:

Member:
Meeting:
Break:
Meal:
Duty:

Member:
Meeting:
Break:
Meal:
Duty:

Member:
Meeting:
Break:
Meal:
Duty:

Nursing Rounds Time:
Nursing Care Planning Conference:
Time:
Patient:
Topic:

Participants:
Suggestions:

Group II
Rooms

Leader:
Meeting:
Break:
Meal:

Member:
Meeting:
Break:
Meal:
Duty:

Member:
Meeting:
Break.
Meal:
Duty:

Member:
Meeting:
Break
Meal:
Duty:

Nursing Rounds Time:
Nursing Care Planning Conference:
Time:
Patient:
Topic:

Participants:
Suggestions:

Form 5411-2 3/84

CASE HISTORY

Personal: Age ________ Sex ________ S. M. W. D. ______ Occupation ____________

Family History: ________________________________

Habits and Social History: ________________________________

Past Medical History (Injuries, Operations, Hospitals, System Review) ________________

History of Present Illness (Onset, Duration, Cause) ________________

Physical Examination: Height ________ Weight ________ Nutrition ____________

Temp. ________ Pulse ________ Resp. ________ Blood Press. S. ________ D. ________ P.P. ________

Head: (including eye, ear, nose, mouth and throat) ________________

Form MS-5-112A 2/84

CASE HISTORY

Thorax and Lungs: ____________________

Heart: (vascular system) ____________________

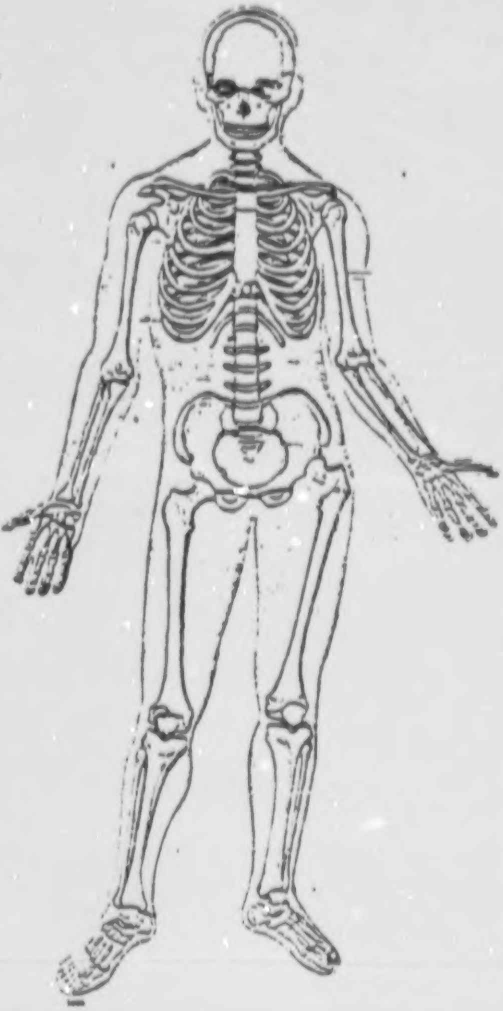
Abdomen: ____________________

Genito-Urinary: (Including female pelvis) ____________________

Neuro-Muscular: (Including Extremities) ____________________

Skin: ____________________

Special Examination: ____________________



Tentative Diagnosis: ____________________

Date ____________________ Examined by ____________________

Form MS-5 (1)-2B 2/84

INTERDISCIPLINARY PROGRESS NOTES

NURSING DISCHARGE SUMMARY

---

1. Chief Complaint, or Reason for Admission ____________________
2. Surgery or Special Procedure(s) Performed ____________________
3. Complications ____________________
4. Patient achieved all outcomes or goals as stated in nursing care plan: ☐ yes ☐ no

   Comments ____________________

5. DISCHARGE: Date ________ Time ________ Mode ____________________

   Accompanied by: ____________________

   Discharge to: ☐ Home ☐ Nursing Home ☐ Other

6. Follow-up Appointment(s): ____________________
7. Home Health Referral: ☐ no ☐ yes ☐ Form Completed, Signed by MD and sent to Home Health Coordinator
8. MEDICATIONS:

   A. Patient's own Medications
   - ☐ Sent home on admission
   - ☐ Return to patient and family at discharge
   - ☐ None
   - ☐ Other ____________________

   B. Patient's Discharge Medications/Prescriptions: ____________________ ☐ None

9. SUPPLIES sent home with patient ____________________ ☐ None
10. DISCHARGE INSTRUCTIONS:

    A. Wound care, Appliance, or Special Procedure: ____________________ ☐ None

    B. Activity Instructions/Limitations: ____________________ ☐ None

    C. Additional Instructions Given by Physician: ____________________ ☐ None

    D. Diet Instructions ____________________

    E. Patient or family verbalized understanding of instructions: ☐ Yes ☐ No

11. Additional Comments ____________________

____

Signature of Nurse Completing Summary

INTERDISCIPLINARY PROGRESS NOTES

Date & Time

Form N4(2)-5 2/84

Date	Notes should be signed by Physician

PROGRESS NOTE

Form MS-5 (11-5) 2/84

FREQUENT OBSERVATION RECORD

Date/ Hour	Blood Pressure		Pulse	Resp.	Temp.	INTAKE			OUTPUT		
						I.V.	Other		Urine	Output	

FORM N4(2)-4 (2/84)

ACTIVITY SHEET

DATE				
HY-GIENE		7-3 p.m.	3-11 p.m.	11-7 a.m.
ACTIV-ITY				
SAFE-TY				
NUTRI-TION				
ELIMI-NATION				
ASSESSMENT				
PATIENT TEACHING				

SIGNATURE AND INITIALS						

PATIENT HISTORY AND NURSING OBSERVATION

SECTION I

ADMISSION DATA

Date ______ Hour ______

Mode of Arrival ______

Accompanied By ______

TPR ______ BP ______

HT ______ WT ______

Valuables: Rings ______

Watch ______

Money ______

Others: ______

Introduced to Hospital Handbook ______

Call Light and Bedside Controls ______

Bathroom and Shower ______

Visiting Rules ______

Smoking Policy ______

Siderail Policy ______

Identification Band On ______

Meal Times ______

Prosthesis: Dentures ______ Contact Lens: ______ Glasses ______

Caps ______ Upper Limb ______ Artificial Eye: R ______

Lower Limb ______ L ______

Hairpiece ______

Disposition of Valuables ______

How can family be reached during hospitalization? ______

Signature of RN or LPN completing Section I: ______

SECTION II

PRESENT ILLNESS

Reason for Hospitalization ______

Onset/Duration ______

ILLNESSES

PREVIOUS ILLNESSES/HOSPITALIZATION	DATES	SURGERIES	DATES

CHRONIC DISEASES (Diabetes, Asthma, Hypertension, Emphysema, Heart Disease, Glaucoma, Seizures)

MEDICATION HISTORY

MEDICATION	DOSAGE	TIMES USUALLY TAKEN – Circle Those Taken Today

Medication Disposition: ______

ALLERGIES SENSITIVITIES

ALLERGIES AND SENSITIVITIES: (Food, Drug, X-Ray Contrast Medium, etc.)

(Record in Red)

Describe Reaction ______

Signature of LPN or RN completing Section II: ______

SECTION III
NURSING OBSERVATIONS

SKIN: (Redness, Bruises, Swelling, Broken Areas, Rash, Dry, Color, Temperature of Skin)

NEURO: (Alert, Oriented, Speech, Dizziness)

RESPIRATORY: (Shortness of Breath, Cough, Sputum, History of Smoking)

CARDIOVASCULAR: (Chest Pain, Heart Rhythm – Regular, Irregular, Varicose Veins, Pulses)

GI: (Distended Abdomen, Elimination Patterns, Appetite, Nausea, Vomiting, Difficulty swallowing, Usual Diet)

GU: (Frequency, Pain, Color of Urine, Discharge)

GYN: (Menstrual History, Vaginal Discharge or Bleeding)

EENT AND MOUTH: (Visual or Hearing Problems, Bleeding Gums, Hoarseness)

EXTREMITIES: (Edema, Moves all Extremities, Color of Nail Beds)

OTHER ASSESSMENTS: (Psychological and Sociological)

PATIENT PROBLEMS: (Include Anticipated Problems and Learning Needs)

1.
2.
3.
4.
5.

Signature of RN Completing Section III:

NUCLEAR MEDICINE

2-80

DEPARTMENT OF NUCLEAR MEDICINE	ORDERED BY:								
BRAIN SCAN		BLOOD VOLUME RBC MASS		DEPARTMENT NUMBER 117					
GALLIUM		RBC SURVIVAL							
LIVER/SPLEEN		THYROID BATTERY T-3, T-4, ETR							
LUNG-PERFUSION		T-3 ONLY		RAST (ALLERGY)		ULTRA SOUND ONLY			
LIVER-LUNG		T-4 ONLY				PREGNANCY ENTIRE 1 & 2		EYE SCAN	
LUNG-VENTILATION		* SCHILLING'S TEST				(1) FETAL AGE BI-PAR DIAM.		CARDIAC SCAN	
CARDIAC SCAN		* SCHILLING'S TEST INT. FAC.				(2) PLACENTAL LOCALIZATION		PERICARDIAL EFFUSION	
* RENAL BATTERY SCAN & RENOGRAM		* DIGOXIN ASSAY				UNUSUAL PREGNANCY		LIVER SCAN ULTRASOUND	
* PANCREAS SCAN		* GASTRIN ASSAY				PELVIC MASS		AORTA SCAN	
BONE SCAN		AUSTRALIAN ANTIGEN						MIDLINE BRAIN	
* THYROID UPTAKE & SCAN		* PLASMA RENIN ANGIOTENSIN		OTHER:				DEPT NO.	CODE
ABDOMINAL SCAN		IGE							

* REQUIRES SPECIAL CONSIDERATIONS - REFER TO MANUAL

DEPARTMENT COPY

NUCLEAR MEDICINE DEPARTMENT

Medical Center

(CHECK ONE)

☐ AMBULATORY

☐ STRETCHER

☐ WHEELCHAIR

☐ BEDSIDE

Date Requisition Filed

Date Scan To Be Done

Requested by

Type of Scan

PATIENT TO BE DISCHARGED TODAY ☐

FILE ONE (1) REQUISITION FOR EACH SCAN

ORDERED BY

R.N.

PERTINENT CLINICAL HISTORY

RADIOGRAPHIC REPORT

FILM NO.

Radiological Associates, P.A.

1-CHART COPY

SIGNATURE OF RADIOLOGIST

541 558

FORM NO. 117-01

Reynolds + Reynolds DAYTON OHIO PRINTED IN U.S.A.

845-01 (Rev 1 84)

THE [illegible] REGISTER COMPANY COLUMBIA S C

EKG - EEG REQUEST

Date Ordered	Date To Be Done	Ordered By

☐ Routine ☐ Pre OP ☐ Stat ☐ Other

DEPARTMENT 124

Qty.	TEST	Qty.	TEST
	3000 ELECTROCARDIOGRAPH		3015 PEDIATRIC ECHO
	3011 TREADMILL		3017 PORTABLE ECHO
	3002 RHYTHM STRIP EKG		
	3004 MINI EXERCISE		138-3500 ELECTROENCEPHALOGRAM
	3016 MAYDAY		138-3501 PORTABLE EEG
	3012 EKG INTERPRETATION FEE		HOLTER MONITOR
	3007 ELECTIVE CARDIOVERSION		3008 0 - 8 HOURS
			3009 9 - 16 HOURS
	3013 ECHOCARDIOGRAM		3010 17 - 24 HOURS

Qty.	CODE	TEST	AMOUNT

EKG - EEG REQUEST

BEST COPY AVAILABLE

MEDICAL CENTER

"Caring For The Community Since 1914"

Electro-encephalographic Report

Dr.

Name: ______________________ Age: ______ Date: __________ Rm. # __________

PURPOSE OF EXAMINATION: (include positive Neurological findings and salient features of Clinical history)

PREVIOUS MEDICATION: (include all sedatives and anti-convulsive drugs administered 48 hours prior to E.E.G. Examination)

E.E.G. FINDINGS:

INTERPRETATION:

E.E.G. Report No.

CPI
A COOPERATIVE PROGRAM INSTITUTION

845 01 (Rev 1 84)

THE STANDARD REGISTER COMPANY COLUMBIA S C

EKG - EEG REQUEST

Date Ordered	Date To Be Done	Ordered By

☐ Routine ☐ Pre OP ☐ Stat ☐ Other

DEPARTMENT 124

Qty	TEST	Qty	TEST
	3000 ELECTROCARDIOGRAPH		3015 PEDIATRIC ECHO
	3011 TREADMILL		3017 PORTABLE ECHO
	3002 RHYTHM STRIP EKG		
	3004 MINI EXERCISE		138-3500 ELECTROENCEPHALOGRAM
	3016 MAYDAY		138-3501 PORTABLE EEG
	3012 EKG INTERPRETATION FEE		HOLTER MONITOR
	3007 ELECTIVE CARDIOVERSION		3008 0 - 8 HOURS
			3009 9 - 16 HOURS
	3013 ECHOCARDIOGRAM		3010 17 - 24 HOURS

Qty	CODE	TEST	AMOUNT

EKG - EEG REQUEST

FILE COPY

MEDICAL CENTER

Electrocardiographic Record

ECG ORDERED BY ________________ M.D.

Previous ECG Yes No	Age	Sex	Race	Hgt.	Wgt.	B.P.	Serial No.	Position	Date

Emergency ☐
Routine ☐
Bedside ☐
Ambulant ☐

COMPUTER DATA (circle 1 in each category)

CLINICAL HISTORY (C)
0 Unknown
1 Diagnosed myocardial infarction
2 Possible ischemia/infarction
3 Pulmonary disease
4 Chronic or recent hypertension
5 Predominant mitral stenosis
6 Aortic stenosis/aortic or mitral regurgitation
7 Congenital heart disease
8 Pericarditis
9 No pertinent clinical history (routine or presurgical ECG)

DRUGS (D)
0 Unknown
1 None of the following
2 Digitalis + antihypertensives
3 Digitalis
4 Quinidine + antihypertensives
5 Quinidine
6 Antihypertensives
7 Diuretics (not antihypertensives)

INTERPRETATION:

CASE#________

MISCELLANEOUS CHARGES

	DATE
AUTHORIZED SIGNATURE	DEPARTMENT

ITEM OR DESCRIPTION	QTY.	DEPT.	CODE	AMOUNT
MISCELLANEOUS CHARGES			TOTAL	

FILE COPY

(CHECK ONE)

☐ AMBULATORY

☐ STRETCHER

☐ WHEELCHAIR

C.T. DEPARTMENT

Medical Center

Date Requisition Filed

Date Scan To Be Done

Requesting Physician

Type of

PATIENT TO BE DISCHARGED TODAY ☐

FILE ONE (1) REQUISITION FOR ALL SCANS THAT ARE TO BE DONE ON THE SAME DAY.

ORDERED BY ______ R.N.

PERTINENT CLINICAL HISTORY

[illegible] REPORT

CHART COPY

547

564

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X-Ray Dept.

Diagnostic Radiology

DEPARTMENT NUMBER 114

Date Exam to be Done

Year of previous x-ray:

X-ray Number:

☐ walk ☐ Wheelchair

☐ stretcher ☐ portable

Requesting Physician:

Written By

(File all exams for one day on one request)

☐ In Patient ☐ Out Patient ☐ Emergency Room

Exam (s) Requested:

Clinical History:

DEPARTMENT

Do Not Mark Below This Line (x-ray dept. use only)

ABDOMEN (FLAT & UPRIGHT)		CYSTOGRAM		HIP		NECK FOR SOFT TISSUE		T TUBE CHOLANGIOGRAM	
ABDOMEN (FLAT)		ELBOW		HIPS (BOTH)		PARANASAL SINUSES		THORACIC SPINE	
ANKLE		ESOPHAGUS		IMAGE INTENSIFIER		PELVIMETRY		TOMOGRAMS	
CERVICAL SPINE WITH OBLIQUES		FACIAL BONES		IVP		PORTABLES		UPPER G I	
CHEST (PA & LATERAL)		FEMUR		IVP (HYPERTENSIVE)		POLYTOMES		UPPER G I & SMALL BOWEL	
CHEST FOR RIBS		FOOT		KNEE		RETROGRADE PYELOGRAM		WRIST	
CHEST (PA)		FOREARM		LOWER LEG		SELLA TURCICA		XEROGRAMS	
COLON (BA ENEMA)		GALLBLADDER		LUMBAR SPINE		SHOULDER			
COLON WITH AIR CONTRAST		GALLBLADDER (REPEAT)		LUMBAR SPINE WITH OBLIQUES		SKULL			
COMPLETE SPINE		HAND		NASAL BONES		SMALL BOWEL			

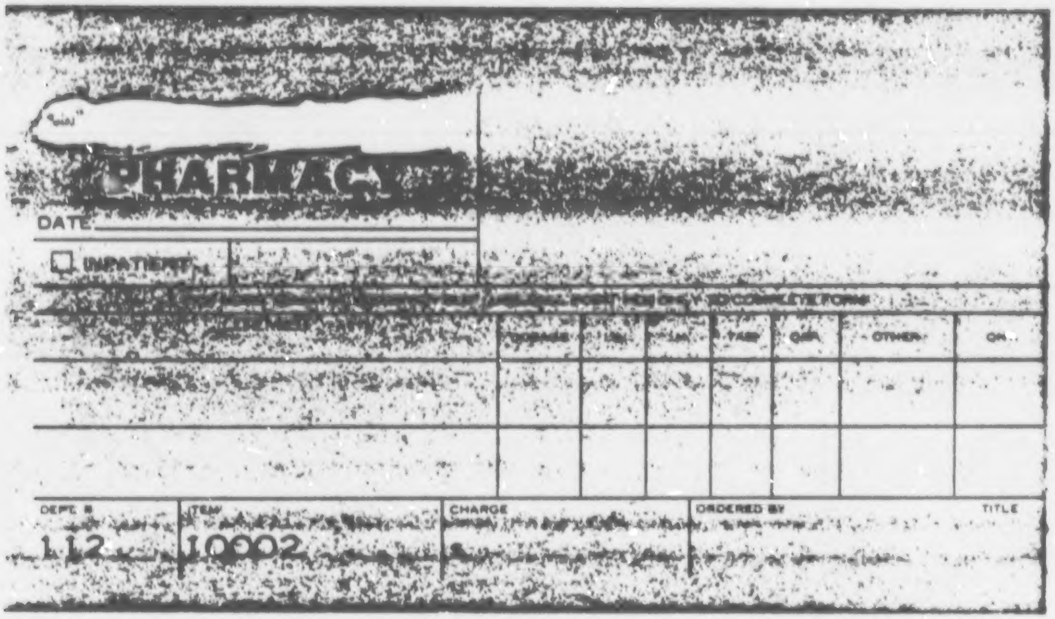
Contrast Media ________

Control Number ________

Time of Injection ________

Tech ________

CIT-59-4 NP-10322



PHARMACY

DATE

☐ INPATIENT

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	OTHER	[illegible]

DEPT. #	ITEM	CHARGE	ORDERED BY	TITLE
112	10002	$		

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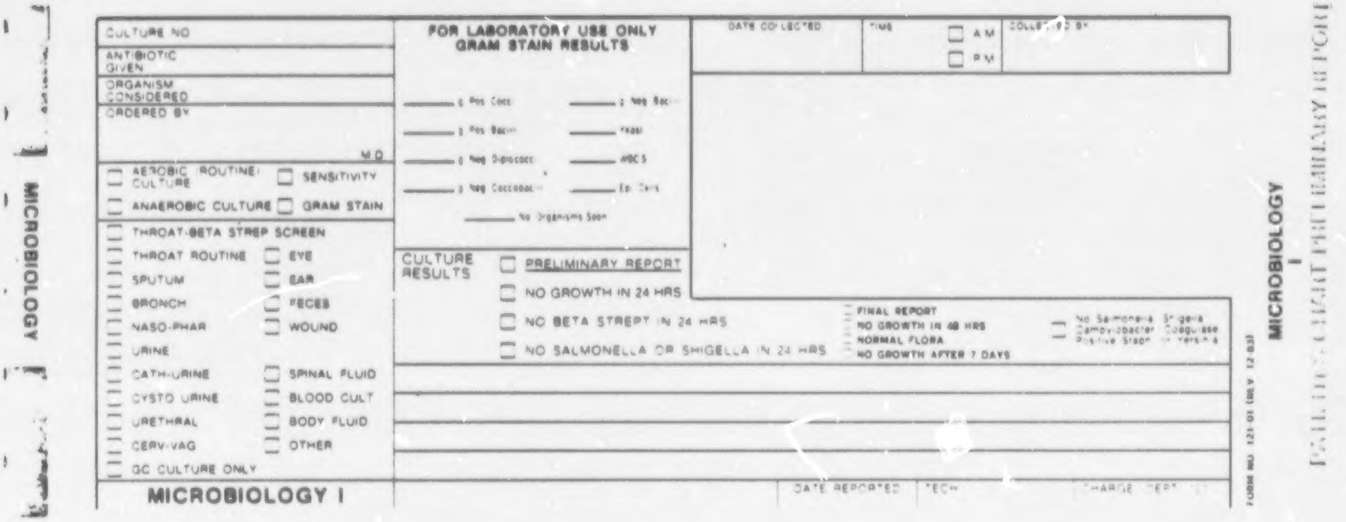


MICROBIOLOGY

CULTURE NO

ANTIBIOTIC GIVEN

ORGANISM CONSIDERED

ORDERED BY

M.D.

☐ AEROBIC (ROUTINE) CULTURE ☐ SENSITIVITY

☐ ANAEROBIC CULTURE ☐ GRAM STAIN

☐ THROAT-BETA STREP SCREEN

☐ THROAT ROUTINE ☐ EYE

☐ SPUTUM ☐ EAR

☐ BRONCH ☐ FECES

☐ NASO-PHAR ☐ WOUND

☐ URINE

☐ CATH-URINE ☐ SPINAL FLUID

☐ CYSTO URINE ☐ BLOOD CULT

☐ URETHRAL ☐ BODY FLUID

☐ CERV-VAG ☐ OTHER

☐ GC CULTURE ONLY

MICROBIOLOGY I

FOR LABORATORY USE ONLY
GRAM STAIN RESULTS

_____ g Pos Cocci _____ g Neg Bacilli

_____ g Pos Bacilli _____ Yeast

_____ g Neg Diplococci _____ WBC'S

_____ g Neg Coccobacilli _____ Epi Cells

_____ No Organisms Seen

CULTURE RESULTS

☐ PRELIMINARY REPORT

☐ NO GROWTH IN 24 HRS

☐ NO BETA STREPT IN 24 HRS

☐ NO SALMONELLA OR SHIGELLA IN 24 HRS

☐ FINAL REPORT
NO GROWTH IN 48 HRS
NORMAL FLORA
NO GROWTH AFTER 7 DAYS

☐ No Salmonella, Shigella, Campylobacter, Coagulase Positive Staph or Yersinia

DATE COLLECTED

TIME ☐ A.M. ☐ P.M.

COLLECTED BY

DATE REPORTED

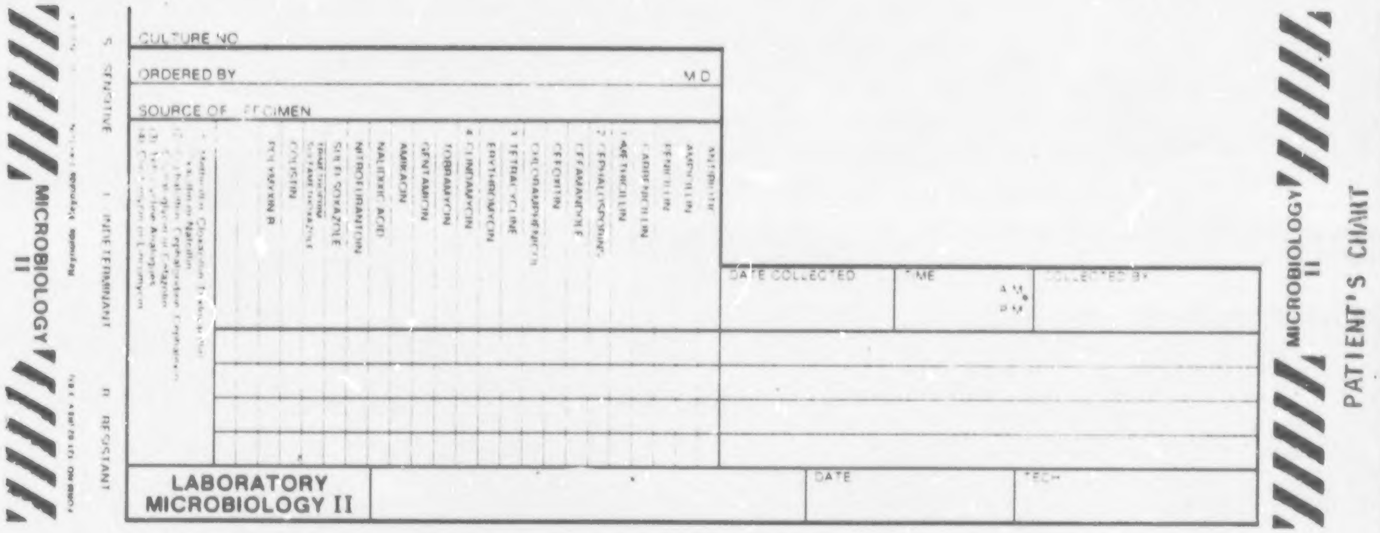
TECH

CHARGE DEPT.

FORM NO. 121-01 (REV. 12-83)

MICROBIOLOGY I

PATIENT'S CHART PRELIMINARY REPORT



MICROBIOLOGY II

S SENSITIVE I INTERMEDIATE R RESISTANT

CULTURE NO

ORDERED BY M.D.

SOURCE OF SPECIMEN

ANTIBIOTIC

AMPICILLIN

PENICILLIN

CARBENICILLIN

1 METHICILLIN

2 CEPHALOSPORINS

CEFAMANDOLE

CEFOXITIN

CHLORAMPHENICOL

3 TETRACYCLINE

ERYTHROMYCIN

4 CLINDAMYCIN

TOBRAMYCIN

GENTAMICIN

AMIKACIN

NALIDIXIC ACID

NITROFURANTOIN

SULFISOXAZOLE

TRIMETHOPRIM SULFAMETHOXAZOLE

COLISTIN

POLYMYXIN B

(1) Methicillin, Oxacillin, Dicloxacillin, Cloxacillin or Nafcillin

(2) Cephalothin, Cephaloridine, Cephalexin, Cephapirin or Cefazolin

(3) Tetracycline Analogues

(4) Clindamycin or Lincomycin

DATE COLLECTED

TIME A.M. P.M.

COLLECTED BY

LABORATORY MICROBIOLOGY II

DATE

TECH

MICROBIOLOGY II

PATIENT'S CHART

BEST COPY AVAILABLE

MICROBIOLOGY III

CULTURE NO	DATE COLLECTED	TIME	A.M. P.M.	COLLECTED BY

MICROBIOLOGY III

MYCOLOGY and/or MYCOBACTERIOLOGY CULTURE

(FUNGUS and/or TUBERCULOSIS, AFB)

SOURCE OF SPECIMEN	ORDERED BY M.D.

AFB CULTURE	PRELIM CULTURE	☐ NO ACID FAST ORGANISM ISOLATED IN 4 WEEKS (FINAL REPORT TO FOLLOW IN 4 WEEKS) ☐ OTHER
{ INCLUDES AFB SMEAR }	AFB SMEAR	☐ NO ACID FAST BACILLI SEEN ☐ OTHER
FUNGUS CULTURE	PRELIM CULTURE	☐ NO YEAST OR FUNGUS ISOLATED IN 3 WEEKS (FINAL REPORT TO FOLLOW IN 3 WEEKS) ☐ OTHER
{ INCLUDES KOH OR INDIA INK PREP }	KOH OR INDIA INK	☐ NO YEAST OR FUNGAL ELEMENTS SEEN ☐ OTHER

OTHER

DATE REPORTED TECH

MICROBIOLOGY III PATIENT'S CHART PRELIMINARY REPORT

MICROBIOLOGY IV

MICROBIOLOGY IV

FECAL EXAMINATION

{ NOT FOR CULTURE USE }

ORDERED BY M.D.

DATE COLLECTED	TIME	A.M. P.M.	COLLECTED BY

MACRO EXAM FORMED FIRM FORMED SOFT NOT FORMED LIQUID MUCOUS BLOODY BARIUM QUANTITY NOT SUFFICIENT [illegible] FOR O & P

OCCULT BLOOD (GUIAC) POS TRACE POS NEG

OVA & PARASITES NO OVA OR PARASITES SEEN
OTHER (SEE PARASITE IDENTIFIED)

AMOEBA (SPECIMEN MUST BE LESS THAN 30 MINUTES OLD)

TRYPSIN [illegible]

NEUTRAL FAT QUALITATIVE MICROSCOPIC SCREENING

OTHER

PARASITES IDENTIFIED AS

BAPTIST MEDICAL CENTER
at COLUMBIA
Columbia, South Carolina

DATE REPORTED TECH INITIALS CHARGE DEPT [illegible]

MICROBIOLOGY IV PATIENT'S CHART

BEST COPY AVAILABLE

845-01 (Rev. 1-84)

THE STANDARD REGISTER COMPANY COLUMBIA S C

EKG - EEG REQUEST

Date Ordered	Date To Be Done	Ordered By

☐ Routine ☐ Pre OP ☐ Stat ☐ Other

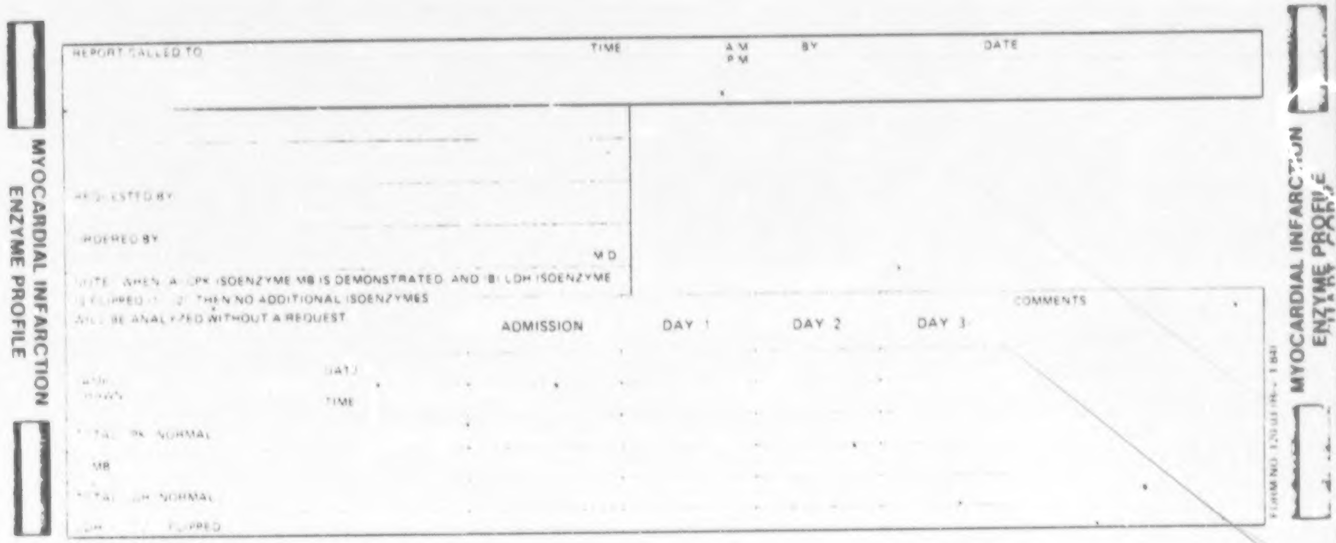
DEPARTMENT 124

Qty.	TEST	Qty.	TEST
	3000 ELECTROCARDIOGRAPH		**3015** PEDIATRIC ECHO
	3011 TREADMILL		**3017** PORTABLE ECHO
	3002 RHYTHM STRIP EKG		
	3004 MINI EXERCISE		**138-3500** ELECTROENCEPHALOGRAM
	3016 MAYDAY		**138-3501** PORTABLE EEG
	3012 EKG INTERPRETATION FEE		HOLTER MONITOR
	3007 ELECTIVE CARDIOVERSION		**3008** 0 - 8 HOURS
			3009 9 - 16 HOURS
	3013 ECHOCARDIOGRAM		**3010** 17 - 24 HOURS

Qty.	CODE	TEST	AMOUNT

EKG - EEG REQUEST

570



MYOCARDIAL INFARCTION ENZYME PROFILE

REPORT CALLED TO TIME A.M. P.M. BY DATE

REQUESTED BY

ORDERED BY M.D.

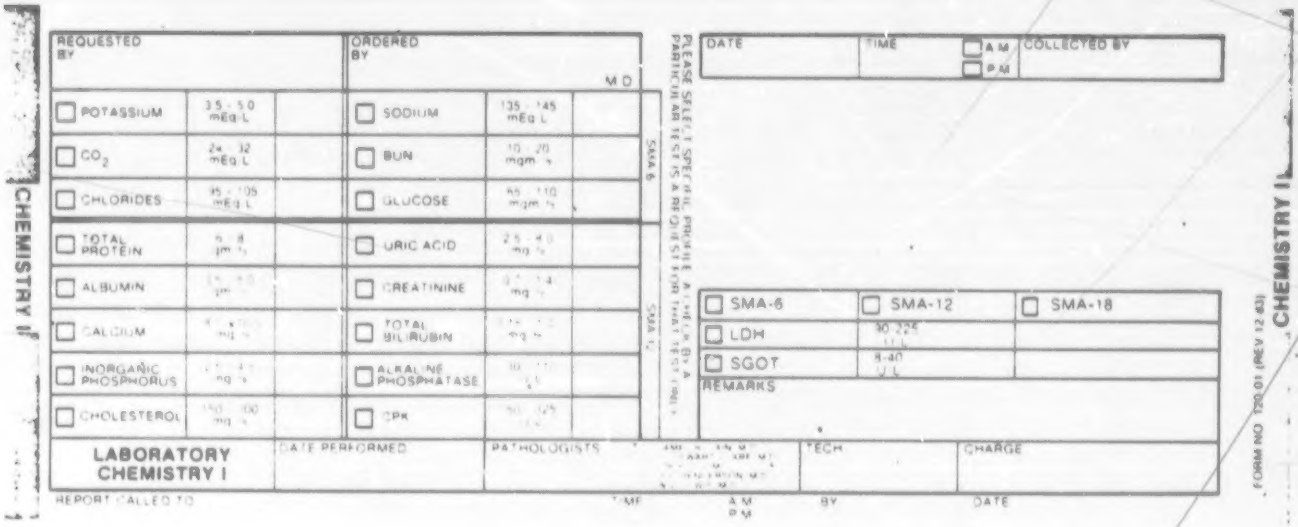
NOTE: WHEN (A) CPK ISOENZYME MB IS DEMONSTRATED AND (B) LDH ISOENZYME IS FLIPPED (1 [illegible] 2) THEN NO ADDITIONAL ISOENZYMES WILL BE ANALYZED WITHOUT A REQUEST

		ADMISSION	DAY 1	DAY 2	DAY 3	COMMENTS
[illegible] DRAWN	DATE					
	TIME					
TOTAL CPK NORMAL						
MB						
TOTAL LDH NORMAL						
LDH [illegible] FLIPPED						

FORM NO [illegible]

MYOCARDIAL INFARCTION ENZYME PROFILE

BEST COPY AVAILABLE



CHEMISTRY II

REQUESTED BY			ORDERED BY M D			
☐ POTASSIUM	3.5 - 5.0 mEq/L		☐ SODIUM	135 - 145 mEq/L		SMA 6
☐ CO_2	24 - 32 mEq/L		☐ BUN	10 - 20 mgm %		
☐ CHLORIDES	95 - 105 mEq/L		☐ GLUCOSE	65 - 110 mgm %		
☐ TOTAL PROTEIN	6 - 8 gm %		☐ URIC ACID	2.5 - 8.0 mg %		SMA 12
☐ ALBUMIN	[illegible] gm %		☐ CREATININE	0.7 - 1.4 mg %		
☐ CALCIUM	[illegible] mg %		☐ TOTAL BILIRUBIN	[illegible] mg %		
☐ INORGANIC PHOSPHORUS	[illegible] mg %		☐ ALKALINE PHOSPHATASE	30 - 110 U/L		
☐ CHOLESTEROL	150 - 300 mg %		☐ CPK	50 - 325 [illegible]		

PLEASE SELECT SPECIFIC PROFILE AT CHECK BY A PARTICULAR TEST IS A REQUEST FOR THAT TEST ONLY

DATE	TIME	☐ A M ☐ P M	COLLECTED BY

☐ SMA-6	☐ SMA-12	☐ SMA-18
☐ LDH	30-225 U/L	
☐ SGOT	8-40 U/L	
REMARKS		

LABORATORY CHEMISTRY I	DATE PERFORMED	PATHOLOGISTS	TECH	CHARGE

REPORT CALLED TO TIME A M P M BY DATE

FORM NO 120.01 (REV 12 83)

CHEMISTRY II

BEST COPY AVAILABLE

COAGULATION STUDIES

BAPTIST MEDICAL CENTER at COLUMBIA, S.C.

ORDERED BY	REQUESTED BY M.D. ROUTINE STAT	DATE	TIME A.M. P.M.	COLLECTED BY

PROTHROMBIN TIME

PATIENT SEC.

LAB NORMAL SEC

PARTIAL THROMBOPLASTIN TIME (ACT.)

PATIENT SEC

LAB NORMAL SEC

FIBRINOGEN

NORMAL 200 - 400 mg/dl

PATIENT mg/dl

BLEEDING TIME DUKE IVY TEMPLATE

NORMAL PATIENT

CLOTTING TIME (LEE WHITE)

NORMAL [illegible] MIN PATIENT

DATE OF TEST

TECH

PATHOLOGISTS JAMES R. [illegible] M.D. F. STEWART [illegible] M.D. [illegible] M.D. [illegible] M.D. [illegible] M.D.

OTHER

REPORT CALLED TO TIME A.M. BY P.M.

LABORATORY COAGULATION STUDIES

COAGULATION STUDIES

573

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LABORATORY
BLOOD BANK I

BLOOD BANK I

Date Collected ____ Time Collected ____ ☐ AM ☐ PM Tech ____

Routine ☐
Stat ☐ Date ____
Ordered by
M.D. ____

Nurse ____
Date and Time of Intended Transfusions
____

Pathologists
JAMES R. CAIN, M.D. W. V. LEWIS, M.D.
F. STEWART CLARE, M.D.
J. B. ELLIS, M.D.
R. F. HENDERSON, M.D.

☐ Whole Blood or Packed Cells may be used ☐ Yes ☐ No
☐ Whole Blood Unit
☐ Packed Cells
☐ Platelet Concentrate
☐ Fresh Frozen Plasma
☐ Albumin ____ gms
☐ Plasma Protein Fraction
☐ Cryoprecipitate
☐ Leukocyte Poor Red B. Cells
☐ Other ____

Donor # ____ Donor Group and Rh ____

Compatible with Recipient Named ____ Recipient Group and Rh ____

Expiration Date ____ Tech ____

Date ____

Release Date ____

Remarks

PRETRANSFUSION CHECK
Before starting the unit I checked the information on this form, the blood container label, the identity of the patient, and found they agree. ____ M.D. R.N.

T. P. R. Before Trans ____

T. P. R. After Trans ____

Time Started ____ Completed ____

Volume Given ____ Date Given ____

RESULTS OF TRANSFUSION ☐ Satisfactory ☐ Reaction

Transfusionist Signature
Signature ____

BLOOD BANK I
CHART COPY

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PHYSICAL THERAPY

Part To Be Treated

Patient Can Walk ☐ Wheel Chair ☐ Stretcher ☐ Bedside Only ☐

Diathermy ☐ Hydrocollator ☐ Ultra Sound ☐ Infra Red ☐

Ordered By Whirlpool ☐ Paraffin Bath ☐

DEPT
Number

134

X	ITEM	X	ITEM	X	ITEM	X	ITEM	X	ITEM
	Heat		Heat and Traction		Electrical Stimulation and Exercise		Muscle Testing Complete		Comb. R 2 Parts Heat and Exercise
	Massage		Heat and Exercise		Gait Training		Comb. R Any 2 Parts Heat		Comb. R 2 Parts Massage and Exercise
	Exercise		Heat, Exercise and Traction		Ultra Violet		Comb. R 2 Parts Heat and Massage		Comb. R 2 Parts Heat and Traction
	Traction		Exercise and Traction		Muscle Testing Extremity		Comb. R 2 Pts. Heat, Massage Exercise and/or Traction		Comb. R 2 Parts Massage
	Heat and Massage		Massage and Traction or Exercise		Heat, Massage and Traction		Massage and Exercise	THERAPIST	
	Heat, Massage and Exercise or Traction		Traction, Massage and Exercise	QUANTITY	DESCRIPTION			CODE	AMOUNT
	Heat, Massage Exercise and Traction		Electrical Stimulation						

THERAPY FILE

PHYSICAL THERAPY

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[redacted] **HEMATOLOGY** [redacted]

FORM NO. 118 01

☐ [illegible] ☐ [illegible] PLATELET ☐ PROFILE W. PLATELET ☐ HCT MICRO
☐ PROFILE ☐ DIFF ☐ RETIC ☐ WINTROBE SED RATE

ORDERED BY M.D.	NURSE	DATE
[illegible]	[illegible] STEWART CLARE M.D. [illegible] BARNARD ELLIS M.D.	H.F. HENDERSON M.D. A. [illegible] LEWIS M.D.
	TEST NO	

TECH

NORMAL VALUES

REPORT CALLED TO

TIME

A.M. P.M.

BY

ROUTINE ☐ STAT ☐ TODAY ☐ ADM ☐ STAT DRAW ☐ RUN ROUTINE ☐

REMARKS

☐ PLATELET COUNT NOT VERIFIED

☐ [illegible] ☐ SEE SEPARATE FORM

TECH

DATE DRAWN

TIME

A.M. P.M.

COLLECTED BY

BAPTIST MEDICAL CENTER AT COLUMBIA, S.C.

URINALYSIS

DO NOT WRITE IN THIS SPACE - FOR LAB USE ONLY

COLLECTION DATE ______________ TIME ______________ AM PM VOIDED ☐ CATH ☐ CLEAN CATCH ☐

ROUTINE ☐ **STAT** ☐ **O.P. SURGERY** ☐

ROUTINE URINALYSIS ☐ MICROSCOPIC ONLY ☐ TEST SCREEN ONLY ☐

OTHER TEST

NURSE ORDERED BY M.D.

SP.G.	COLOR	W.B.C.	hpF
pH		R.B.C.	hpF
PROTEIN		EPI CELLS	
GLUCOSE	REDUCING SUBSTANCE	BACTERIA	
KETONES		CASTS/LPF	
BILIRUBIN		CRYSTALS	
BLOOD		MUCOUS	

LABORATORY URINALYSIS	DATE	PATHOLOGISTS JAMES R. CAIN M.D. F. STEWART CLARE M.D. J.B. ELLIS M.D. H.F. HENDERSON M.D. W.V. LEWIS M.D.	TECH

REPORT CALLED TO TIME A.M. P.M. BY

FORM NO. 125 01 (REV. 12/83)

URINALYSIS

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LABORATORY MISCELLANEOUS

REQUESTED BY ORDERED BY M.D.

SPECIMEN:	DATE	TIME ☐ A.M. ☐ P.M.	COLLECTED BY
TEST REQUESTED			

DEPT	CODE	TEST

LABORATORY MISCELLANEOUS	DATE	PATHOLOGISTS JAMES R. CAIN, M.D. F. STEWART CLARE, M.D. J.B. ELLIS, M.D. H.F. HENDERSON, M.D. W.V. LEWIS, M.D.	TECH	

[illegible] TIME A.M. P.M. DATE BY

LABORATORY MISCELLANEOUS

Form No. 999.01 (Rev 12 83)

PATIENT'S CHART

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